APPENDIX

Supreme Court, U. S.
FILED
DEC 30 1977
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

October Term, 1977

No. 77-240

ST. PAUL FIRE & MARINE INSURANCE CO., AETNA CASUALTY & SURETY CO., TRAVELERS INDEMNITY OF RHODE ISLAND, TRAVELERS INDEMNITY CO. OF RHODE ISLAND, TRAVELERS INSURANCE CO., HARTFORD CASUALTY COMPANY and HARTFORD FIRE INSURANCE CO.,

Petitioners,

v.

DAVID M. BARRY, M.D., LEROY S. CHAPNICK, M.D., WALTER C. COTTER, M.D., PAUL J. M. HEALEY, M.D., ANTHONY F. MERLINO, M.D., PAUL B. METCALF, M.D., H. GERALD ROCK, M.D., and ROSARIO V. TOMASELLI, M.D.,

and

PENNY ANDREW, CONSTANCE V. BOISSE, CHRISTOPHER DANIELS, ARTHUR M. FERLAND, GLADYS L. SPAIGHT, and ALPHONSE D. VITULLO,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

---

Petition for Certiorari Filed August 12, 1977
Certiorari Granted October 31, 1977

TABLE OF CONTENTS

PAGE

Docket Entries in the United States District Court for the District of Rhode Island 1

Docket Entries in the United States Court of Appeals for the First Circuit 10

Amended Complaint 15

Opinion of the District Court of the United States for the District of Rhode Island 39

Opinion of the United States Court of Appeals for the First Circuit

Majority Opinion 51

Dissenting Opinion 72

Judgment of the United States Court of Appeals for the First Circuit 76

FEDERAL STATUTES

15 U.S.C. §1 (Supp. V, 1975) 77

15 U.S.C. §2 (Supp. V, 1975) 77

15 U.S.C. §15 (1970) 77

15 U.S.C.A. §26, 90 Stat. 1396 (1976) 78

15 U.S.C. §1011 (1970) 79

15 U.S.C. §1012 (1970) 79

15 U.S.C. §1013 (1970) 79

28 U.S.C. §1254 (1970) 80

28 U.S.C.A. §1331, 90 Stat. 2721 (1976) 81

28 U.S.C. §1337 (1970) 81

PAGE

Federal Rules of Civil Procedure
Rule 12 82

STATE STATUTES AND REGULATIONS

Title 27—Insurance, Chapter 9—Casualty Insurance Rating

R.I. Gen. Laws §27-9-4. Considerations in making of rates 86

R.I. Gen. Laws §27-9-7. Filing of rate plans and systems 86

R.I. Gen. Laws §27-9-15. Review of rates not covered by filings 87

R.I. Gen. Laws §27-9-16. Disapproval of filing within waiting period 88

R.I. Gen. Laws §27-9-18. Disapproval of filing after review period—Removal of discrimination 88

R.I. Gen. Laws §27-9-19. Hearings on application by persons aggrieved by filing—Order terminating filing—Removal of discrimination 89

R.I. Gen. Laws §27-9-42. False or misleading information 90

R.I. Gen. Laws §27-9-45. Penalty for violations 90

R.I. Gen. Laws §27-9-46. Suspension or revocation of licenses 91

Title 27—Insurance, Chapter 29—Unfair Competition and Practices

R.I. Gen. Laws §27-29-1. Declaration of purpose 92

R.I. Gen. Laws §27-29-2. Definitions 92

PAGE

R.I. Gen. Laws §27-29-3. Unfair methods of competition or unfair and deceptive acts or practices prohibited 92

R.I. Gen. Laws §27-29-4. Unfair methods of competition and unfair or deceptive acts or practices defined 92

R.I. Gen. Laws §27-29-4.1. Cancellation of insurance prohibited 98

R.I. Gen. Laws §27-29-4.2. Penalty 98

R.I. Gen. Laws §27-29-5. Hearings—Witnesses—Appearances—Production of books—Service of process 99

R.I. Gen. Laws §27-29-6. Cease and desist orders and modifications thereof 101

R.I. Gen. Laws §27-29-7. Judicial review of cease and desist orders 101

R.I. Gen. Laws §27-29-8. Procedure as to unfair methods of competition and unfair or deceptive acts or practices which are not defined 103

R.I. Gen. Laws §27-29-9. Penalty 105

R.I. Gen. Laws §27-29-10. Provisions of act additional to existing law 105

R.I. Gen. Laws §27-29-11. Separability provision 105

Title 42—State Affairs and Government, Chapter 14.1—Department of Business Regulation—Regulatory Authority — Medical Malpractice Insurance

R.I. Gen. Laws §42-14.1-1 (Enactment of January 12, 1976) 106

PAGE

R.I. Gen. Laws §42-14.1-1 (As amended May 14, 1976) 109

Title 42—State Affairs and Government, Chapter 35—Administrative Procedures

R.I. Gen. Laws §42-35-15. Judicial review of contested cases 111

Title 39—Public Utilities and Carriers

R.I. Gen. Laws §39-3-13. Emergency suspension of rate schedules 113

R.I. Department of Business Regulation—Insurance Division — Emergency Regulation XXI (Effective June 16, 1975) 114

Medical Malpractice Joint Underwriting Association of Rhode Island

Article I—Plan of Operation 128

Article II—Operating Principles 141

R.I. Department of Business Regulation—Insurance Division — Regulation XXI (Effective April 9, 1976) 147

Docket Entries in the United States District Court for the District of Rhode Island

UNITED STATES DISTRICT COURT

District of Rhode Island

Civil Action No. 75-176

David M. Barry, M.D., Leroy S. Chapnick, M.D., Walter C. Cotter, M.D., Paul J. M. Healey, M.D., Anthony F. Merlino, M.D., Paul B. Metcalf, M.D., H. Gerald Rock, M.D., and Rosario V. Tomaselli, M.D.,

and

Penny Andrew, Constance V. Boisse, Christopher Daniels, Arthur M. Ferland, Gladys L. Spaight, and Alphonse D. Vitullo,

Plaintiffs,

against

St. Paul Fire & Marine Insurance Co., Aetna Casualty & Surety Co., Travelers Indemnity of Rhode Island, Travelers Indemnity Co. of Rhode Island, Travelers Insurance Co., Hartford Casualty Company and Hartford Fire Insurance Co.,

Defendants.

Date	Proceedings
1975	
June 4	Complaint filed together with appearance of Leonard Decof, Esq.
	Summons issued returnable 20 days after service.

Docket Entries in the United States District Court

Date	Proceedings
1975	
June 5	Pltffs' Motion for Production of Documents, etc. filed.
	Order Re: Pltff's Motion for Production of of Documents, etc granted and Deft's if they so desire, may file a motion to quash this order no later than June 13, 1975 entered and filed. (j)
6	Summons returned duly served and filed. (j)
5	Hearing on Motion to Compel. Motion Granted. Order entered and filed. (tjw)
10	Appearance of Kirk Hanson, Esq. as Attorney for St. Paul Fire & Marine Ins. Co. filed.
11	Deft. St. Paul's Mot. to Quash Order of June 5, 1975 filed. (tjw)
12	Affidavit of Thomas H. Swain filed as Exhibit A to St. Paul's Motion to Quash. (tjw)
	St. Paul Motion to file supplemental memorandum of law granted. (See face of Motion)
	Defts' Travelers Indemnity of R.I. Travelers Indemnity Co. of R.I. and Travelers Insurance Co's Motion to Quash Order to Produce Embodying Supporting memorandum filed together with appearance of Joseph V. Cavanagh, Esq.
13	Deft. Aetna Casualty and Surety Company's Motion to Quash filed together with appearance of George Vetter, Esq.

Docket Entries in the United States District Court

Date	Proceedings
1975	
June 18	Affidavit of Raymond H. Deck and Affidavit of Claude E. Glaser, filed. (d)
	Deft Hartford Casualty Company and Hartford Fire Ins. Co's Motion to Quash an Order filed together with appearance of Joseph Kelly, Esq.
25	Appearance of Walker B. Comegys, Esq., as co-counsel for St. Paul Fire & Marine Insurance Company filed. (A)
	Stipulation Re: Time for filing Deft's answers or motions in response to the complaint is hereby extended to August 15, 1975 entered and filed. (j)
July 2	Stipulation and Order Re: The time for filing Pltff's response to Deft's Motion to Quash is hereby extended to August 8, 1975 entered and filed. (j)
28	Amended Complaint filed. F
Aug. 4	Deft's Answer to amended complaint.
	Deft's Motion to Dismiss Count I of Pltff's amended complaint. F.
5	Pltffs' Motion for Class Certificate filed. F.
8	Pltffs' memorandum in opposition to motions to quash filed. F.
13	Deft's objection to Pltff's Motion for class certification filed. F.
14	Motion of Hartford Fire Ins. to Dismiss filed. F.

Docket Entries in the United States District Court

Date	Proceedings
1975	
Aug. 14	ORDER allowing Aetna Casualty until 9/3/75 to respond entered and filed.
15	Deft's Motion to Dismiss Count I filed. s
	Answer of Deft as to Counts II, III and IV filed. s
	Objection to Motion for Class Certification filed. s
22	Defendants' Travelers Indemnity of R.I., Travelers Indemnity Co. of R.I. and Travelers Insurance Co.'s Objection To And Request To Postpone Consideration of Pltffs' Motion For Class Certification filed. (A)
Sept. 3	Motion of the Aetna Casualty & Surety Company to Dismiss Counts I, II and III of the Amended Complaint and for Summary Judgment as to Count IV of the amended Complaint filed. (j)
	The Aetna Casualty & Surety Company's Objection to and request to postpone consideration of Pltffs' Motion for Class Certification filed. (j)
5	Letter re: Pre-trial Conference for Thursday, September 25, 1975 filed. s
Oct. 20	First Preliminary Pretrial Order Entered and filed. (A)
23	Appearance of Sidney S. Rosdeitcher, Esq., and Jack Hassid, Esq., attorneys for the defendant, The Aetna Casualty and Surety Company filed. (A)

Docket Entries in the United States District Court

Date	Proceedings
1975	
Oct. 24	ORDER LETTER re Motions to Dismiss and Summary Judgment entered and filed.
Nov. 7	Pltff's Motion for Extension of time to file additional memoranda and Order granting same until Nov. 10, 1975 entered and filed. (j)
	Deft Travelers Indemnity of R.I., Travelers Indemnity Company of R.I. and Travelers Insurance Company's Motion to Dismiss Counts II, III and IV of the Amended Complaint filed. (j)
	Motion of Deft. St. Paul Fire & Marine Insurance Company for Summary Judgment Against Pltffs on count IV of Pltffs' Amended Complaint filed.
	Motion of Deft. St. Paul Fire & Marine Ins. Co. to Dismiss Counts II and III of Pltffs' Amended Complaint filed. (j)
11	ORDER entered and filed. Time to file additional memoranda extended to and including November 12, 1975 at 9:00 A.M. tjw
19	Hearing on Motions to Dismiss and Motion for Summary Judgment. All Counts Dismissed by Court. If Mr. Mandell wants to Dismiss R. I. Corp., Crt. will consider abstention. Motion to be filed this week. Brief within 1 week from filing of Motion. Defts. Answer within 1 week. Defts. to prepare Order today. tjw

DATE	PROCEEDINGS
1975	
Nov. 21	Pltffs' Motion for Leave to File a Second Amended Complaint, with Amended Complaint attached. tjw
Dec. 1	Deft. Aetna Casualty & Surety Company's Objection to pltffs' Motion for Leave to File a Second Amended Complaint filed. (j)
1	Second Amended Complaint filed. z
2	Opinion Re: All four Counts of Pltffs' Amended Complaint are hereby dismissed and filed.
	Judgment entered and filed for All Defts on Count I of the Amended Complaint, no order to be entered as to Counts II III and IV of Pltffs' Amended Complaint pending decision by this court on Pltffs' Motion to file a Second Amended Complaint and Defts shall have 10 days to file motion and pltffs' shall have 10 days to respond entered and filed. (j)
4	Deft. Hartford Casualty Company and Hartford Fire Insurance Co's Objection to Pltff's Motion for leave to file a second amended complaint filed. (j)
5	Objction of Travelers Insurance Co. to Pltffs' Motion for Leave to file a Second Amended Complaint. (tjw)
9	Pltffs' Motion for Leave to file a Second Amended Complaint granted. (see face of motion) tjw

DATE	PROCEEDINGS
1975	
Dec. 18	Deft. St. Paul Fire & Marine Insurance Motion to Dismiss Counts 1, 2, and 3 of Second Amended Complaint and for Summary Judgment on Count 3. tjw
29	Motion of the Aetna Casualty & Surety Company to Dismiss Counts I and II of the Second Amended Complaint and for Summary Judgment as to Count III of the Second Amended Complaint filed. (d)
30	Motion of Defts Hartford Fire Insurance Company and Hartford Casualty Company to Dismiss Pltff's Second Amended Complaint filed. (d)
29	Motion of Deft Travelers Insurance Company to Dismiss Counts I, II and III of Pltffs' Second Amended Complaint filed. (d)
29	Pltffs' Notice of Appeal from Dismissal of Count 1 as against all defendants. tjw
	Bond for Costs on Appeal filed. tjw
1976	
Jan. 13	Motion for Stay of Proceedings filed. F.
	Deft. Aetna's Objection to Pltffs' Motion for Stay filed. F.
20	Deft., Travelers Insurance Company, Objection to Pltffs' Motion for a stay of Proceedings in Trial Court filed. (d)
22	Order Re: Pltffs' motion for a stay of proceedings denied and filed. (j)

Docket Entries in the United States District Court

Date	Proceedings
1976	
Jan. 22	Pltffs' may file additional memos pertaining to defts Motion to dismiss or for summary Judgment on or before Jan. 29, 1976. Defts may respond before Feb. 5, 1976.
Feb. 24	Clerk's Certificate filed. (d)
24	Record on Appeal forwarded to First Circuit court of Appeals. (d)
26	ORDER of Circuit Court dismissing appeal filed. /i
Mar. 17	Affidavit of John J. Messina delivered on Nov. 7, 1975 but filed in clerk's Office March 17, 1976 filed. (j)
19	OPINION re: Count III of the Second Amended Complaint is dismissed without prejudice. The Court will abstain from exercising jurisdiction over Counts I and II, and these counts are therefore dismissed. Defendants Aetna's and St. Paul's motions for summary judgment on Count III are granted; defendant Travelers' motion is denied. Defendants shall prepare an order accordingly, entered and filed. (p)
Apr. 1	ORDER Re: Defts' Motions to dismiss counts I and II of Pltffs' second amended complaint granted; Motions of Defts', Aetna Casualty and Surety Company and St. Paul Fire & Marine Insurance Co. for summary judgment with respect to count III of Pltff's second amended complaint

Docket Entries in the United States District Court

Date	Proceedings
1976	
	granted; Motion of deft Travelers Insurance co. for summary judgment on count III of Pltffs' second amended complaint denied; Motions of defts Hartford Casualty Company and Hartford Fire Insurance Co. and Travelers Insurance Co. to dismiss Count III of Pltffs' second amended complaint for failure to comply with Rule 9(b) of the Federal Rules of Civil Procedure granted. Judgment may be entered in accordance with this order. Entered and filed. (d)
2	Deft., Aetna Casualty & Surety Co., Motion for entry of judgment filed. (d)
14	JUDGMENT entered for Defendants, entered and filed. (d)
May 5	Notice of Appeal from the dismissal of the Pltffs' second amended complaint, as against all Defts as specified in Judgment entered on April 14, 1976 in favor of the Defts filed. (d)
	Costs appeal bond filed. (d)
14	Clerk's Certificate filed. (d)
	Record on Appeal forwarded to First Circuit Court of Appeals. (d)

Docket Entries in the United States Court of Appeals for the First Circuit

UNITED STATES COURT OF APPEALS

FOR THE FIRST CIRCUIT

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

Case No. 76-1226

DAVID M. BARRY, M.D., LEROY S. CHAPNICK, M.D., WALTER C. COTTER, M.D., PAUL J. M. HEALEY, M.D., ANTHONY F. MERLINO, M.D., PAUL B. METCALF, M.D., H. GERALD ROCK, M.D., and ROSARIO V. TOMASELLI, M.D.,

and

PENNY ANDREW, CONSTANCE V. BOISSE, CHRISTOPHER DANIELS, ARTHUR M. FERLAND, GLADYS L. SPAIGHT, and ALPHONSE D. VITULLO,

Plaintiffs,

against

ST. PAUL FIRE & MARINE INSURANCE CO., AETNA CASUALTY & SURETY CO., TRAVELERS INDEMNITY OF RHODE ISLAND, TRAVELERS INDEMNITY CO. OF RHODE ISLAND, TRAVELERS INSURANCE CO., HARTFORD CASUALTY COMPANY and HARTFORD FIRE INSURANCE CO.,

Defendants.

DATE	FILINGS—PROCEEDINGS
1976	
May 18	Record on appeal received and filed and case docketed.

Docket Entries in the United States Court of Appeals

DATE	FILINGS—PROCEEDINGS
1976	
24	Appearance of Leonard Decof for appellants filed. Appearance of Kirk Hanson for appellee, St. Paul Fire & Marine Ins. Co., filed.
25	Appearance of Walker B. Comegys for appellee, St. Paul Fire, etc., filed.
26	Appearance of Joseph V. Cavanagh for defendant filed.
27	Appearance of Mark S. Mandell for co-counsel for appellant filed.
May 28	Appearance of Sidney S. Rosdeitcher and Jack Hassid for appellee, Aetna Life & Casualty Co., filed. Appearance of Charles Lister for appellees filed.
June 1	Appearances of Thomas D. Gidley and Stephen J. Carlotti for appellee filed.
1	Motion filed. Order (Coffin, Ch.J.) enlarging time for filing of statement of issues and designation of contents to June 7, 1976. Notices mailed.
8	Statement of issues and designation of contents filed.
18	Motion filed. Order (Coffin, Ch.J.) enlarging time for filing brief and appendix for appellants to 7-27-76. Notices mailed.
18	Counterdesignation by appellees of the contents of the appendix received and filed.

Date	Filings—Proceedings
1976	
30	Appellees' motion to strike issues I. A. and I. B. from appellants' statement of issues and memorandum in support of appellees' motion to strike received and filed.
July 9	Petition for leave to file an amended notice of appeal; Application for extension of time to file appellants' brief; Appellants' objection to motion to strike issues 1A and 1B from statement of issues; Memorandum of points and authorities in opposition to appellees motion to strike issues 1A and 1B from appellants' statement of issues, filed.
July 14	Appellees' objection to appellant's request to file an amended notice of appeal. Appellees notice of joining appellant's request for an enlargement of time.
20	Order (Coffin, Ch.J.) enlarging time for filing brief for appellant and the appendix to three weeks after the decision on motion to strike. Notices mailed.
Aug. 12	Order (Coffin, Ch.J.) denying motion to strike and denying countermotion for leave to amend notice of appeal. Notices mailed.
25	Motion filed. Order (Coffin, Ch.J.) granting leave to appellants to file a brief of 75 pages of standard typographic printing or 100 pages by any other process. Notices mailed.

Date	Filings—Proceedings
1976	
27	Motion filed. Order (Coffin, Ch.J.) enlarging time for filing brief for appellant and appendix to Sept. 15, 1976. Notices mailed.
Sept. 15	Brief for appellant and appendix filed.
21	Motion filed. Order (Coffin, Ch.J.) enlarging time for filing brief for appellees to October 21, 1976. Notices mailed.
Oct. 21	Brief for appellees Aetna Casualty & Surety Co., Hartford Casualty Company and Hartford Fire Insurance Company, filed. Addendum to brief for appellees filed. Brief for appellees St. Paul Fire & Marine Ins., Cor [sic] and Travelers Ins. Co filed.
Oct. 26	Assigned for hearing at the November, 1976, session.
Nov. 3	Heard by Coffin, Campbell and Gignoux, J.J.
29	Motion filed. Order (Coffin, Ch.J.) enlarging time for filing appellants' further memorandum to and including December 1, 1976. Notices mailed.
Dec. 1	Appellants' post argument memorandum filed.
9	Defendants-Appellees' Joint Supplemental Memorandum filed.

Docket Entries in the United States Court of Appeals

Date	Filings—Proceedings
1977	
May 13	JUDGMENT: The judgment of the district court is affirmed in part; and the said judgment is vacated in part and remanded in part for further proceedings consistent with the opinion of the court filed this day. Appellants are to recover one half costs. Notices mailed. Opinion of the Court by Coffin, Ch.J., dissenting opinion by Campbell, J.
June 3	Verified and itemized bill of costs filed for appellants.
6	Motion filed. Order (Coffin, Ch.J.) staying mandate pending filing and disposition of petition for writ of certiorari in the Supreme Court to be filed by July 11, 1977. Notices mailed.
July 12	Motion filed. Order (Coffin, Ch.J.) staying mandate pending the filing and disposition of a petition for writ of certiorari in the Supreme Court to be filed by August 15, 1977, with notice of such filing to be filed promptly with the Clerk of this court. Notices mailed.
Aug. 17	Notice of filing petition for certiorari (77-240) August 12, 1977.
Nov. 7	Order of Supreme Court granting certiorari October 31, 1977.

Amended Complaint

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF RHODE ISLAND

C. A. No. 75-0176

David M. Barry, M.D., Leroy S. Chapnick, M.D., Walter C. Cotter, M.D., Paul J. M. Healey, M.D., Anthony F. Merlino, M.D., Paul B. Metcalf, M.D., H. Gerald Rock, M.D., and Rosario V. Tomaselli, M.D.

and

Penny Andrew, Constance V. Boisse, Christopher Daniels, Arthur M. Ferland, Gladys L. Spaight, and Alphonse D. Vitullo

v.

St. Paul Fire & Marine Insurance Co., Aetna Casualty & Surety Co., Travelers Indemity of Rhode Island, Travelers Indemnity Co. of Rhode Island, Travelers Insurance Co., Hartford Casualty Company and Hartford Fire Insurance Co.

AMENDED COMPLAINT

COUNT I

I

JURISDICTION

1. This action arises under the Sherman Anti Trust Act §§1 and 2 (15 U.S.C.A. §§1 and 2) and Clayton Act §§4 and 16 (15 U.S.C.A. §§15 and 26) as hereinafter more fully appears.

2. The matter in controversy exceeds the sum or value of Ten Thousand Dollars ($10,000.00) exclusive of interest and costs, and arises under the laws of the United States (28 U.S.C.A. §1331).

3. The matter in controversy arises under an act of Congress regulating commerce and protecting trade and commerce against unreasonable restraints and monopolies (28 U.S.C.A. §1337).

II

Parties

1. Plaintiffs David M. Barry, M.D., of Providence, Rhode Island, Leroy S. Chapnick, M.D., of North Providence, Rhode Island, Walter C. Cotter, M.D., of Providence, Rhode Island, Paul J. M. Healey, M.D., of Rumford, Rhode Island, Anthony F. Merlino, M.D., of North Providence, Rhode Island, Paul B. Metcalf, Jr., M.D., of Pawtucket, Rhode Island, H. Gerald Rock, M.D., of Warwick, Rhode Island and Rosario V. Tomaselli, M.D., of Providence, Rhode Island are practicing physicians licensed to practice medicine in the State of Rhode Island, who bring this action on behalf of themselves and all other similarly situated physicians who are licensed to practice in the State of Rhode Island.

2. Plaintiffs Penny Andrew of Pawtucket, Rhode Island, Constance V. Boisse of Pawtucket, Rhode Island, Christopher Daniels of Pawtucket, Rhode Island, Arthur M. Ferland of Providence, Rhode Island, Gladys L. Spaight of East Providence, Rhode Island and Alphonse

D. Vitullo of Barrington, Rhode Island are citizens of the State of Rhode Island presently under the care of physicians, and who are or may require medical care in the future, who bring this action on behalf of themselves, and all persons presently receiving medical care and attention, or who in the future may require medical care and attention from physicans and medical personnel in the State of Rhode Island.

3. The within action is maintainable as a class action be each of the aforedescribed classes of plaintiffs because:

a. Each class is so numerous that joinder of all its members is not practical.

b. There are questions of law or fact common to each class.

c. The claims of the representative parties are typical of the claims of their respective Classes.

d. The representative parties will fairly and adequately protect the interests of their respective classes.

4. The defendants, St. Paul Fire & Marine Insurance Co., (hereinafter referred to as "St. Paul") and Aetna Casualty & Surety Co., (hereinafter referred to as "Aetna"), are each national corporations licensed to sell insurance in the State of Rhode Island, all of which have been, at all times mentioned herein, and for a long time prior thereto engaged in the business of selling insurance in the State of Rhode Island.

5. The defendants, Travelers Indemnity of Rhode Island, Travelers Indemnity Co. of Rhode Island and Travelers Insurance Co., (hereinafter collectively referred to as "Travelers") are affiliated insurance companies, having common ownership, and are an integral part of a group of corporations doing business nationally and licensed to sell insurance in the State of Rhode Island, which have been, at all times mentioned herein, and for a long time prior thereto engaged in the business of selling insurance in the State of Rhode Island.

6. The defendants, Hartford Casualty Company and Hartford Fire Insurance Co., (hereinafter collectively referred to as "Hartford") are affiliated insurance companies, having common ownership, and are an integral part of a group of corporations doing business nationally and licensed to sell insurance in the State of Rhode Island, which have been, at all times mentioned herein, and for a long time prior thereto engaged in the business of selling insurance in the State of Rhode Island.

III

Nature of Interstate Commerce

7. Defendants, St. Paul, Aetna, Travelers and Hartford are corporations which presently are and have been for a long time prior hereto, engaged in the business of selling general liability insurance on a national scale, including the sale of such general liability insurance in the state of Rhode Island.

8. The defendants' insurance businesses are not separated into fifty (50) distinct territorial compartments which function in isolation from each other. Inter-relationships, interdependence and integration of activities in all of the states in which they operate are practical aspects of the defendants' methods of doing business.

9. All named defendants are, at the present time, and have, for a long period been, engaged in selling medical malpractice insurance to physicians, hospitals and other medical personnel in the state of Rhode Island and elsewhere throughout the United States within the ordinary conduct of their business. Premiums for this medical malpractice insurance are being, and have been, received from physicians, hospitals and other medical personnel in the state of Rhode Island and are and have been applied by the defendants in various aspects of the operation of their business outside the state of Rhode Island.

10. The defendant corporations own property, pay taxes, insure personnel, firms and corporations and otherwise engage in commerce throughout the United States.

11. Plaintiff physicians and hospitals are engaged in interstate commerce in that they purchase goods and materials from sources located throughout the United States, purchase and sell services from and to residents of other states, give medical education to persons who practice or who go on to practice medicine in various states, and engage in research, development and scientific studies for the advancement of medicine, health services and the cure

and treatment of diseases, and for the health of and to the benefit of persons throughout the United States.

IV

Cause of Action

12. The defendants, St. Paul, Aetna, Travelers, and Hartford over a period of years have so conducted their respective businesses of selling medical malpractice insurance in the State of Rhode Island that they have, at the present time, acquired a total monopoly in the sale of medical malpractice insurance to the end that all physicians, hospitals and other medical personnel buying medical malpractice insurance in the State of Rhode Island buy said insurance from defendants, St. Paul, Aetna, Travelers, and Hartford.

13. In establishing the aforesaid monopoly, the defendant corporations have created a condition whereby all physicians, hospitals and other medical personnel in the State of Rhode Island have come to rely upon said defendants for their medical malpractice insurance.

14. Said defendant corporations, and each of them, for a great number of years have realized large profits from the sale of medical malpractice insurance in the State of Rhode Island.

15. Said defendant corporations and each of them, for a great number of years have realized large profits from the sale of insurance other than medical malpractice in-

surance to persons, firms, and corporations in the State of Rhode Island.

16. Said defendants and each of them, have been permitted to realize said large profits from the sale of medical malpractice and other insurance by virtue of the fact that they have been licensed by the Insurance Commissioner of Rhode Island to sell insurance within the State of Rhode Island.

17. By virtue of the grant of said license to sell insurance in the State of Rhode Island, and by virtue of their creation of a monopoly in the sale of medical malpractice insurance, the defendant corporations, and each of them have obligations to the members of each of the aforementioned plaintiff classes and to the citizens of the State of Rhode Island concomitant with or counterbalancing to the aforesaid licenses and privilege granted them.

18. By virtue of having created the aforesaid monopolies in the sale of medical malpractice insurance, said defendant corporations have caused all physicians, hospitals and other medical personnel as well as all patients and prospective patients and tax payers in the State of Rhode Island to be in a position of vulnerability and total depenence upon the good faith, integrity, and fairness of the defendant corporations.

19. For a long period of years, the plaintiff physicians, hospitals and other medical personnel have become accustomed to renewing their medical malpractice insurance with the defendant companies, and have come to rely on

the fact that such insurance would be renewed, and upon a reasonable price bearing a reasonable relation to economic conditions.

20. The defendants and each of them are, and have been, aware that under the present social and economic conditions, it is virtually impossible for a physician, hospital or other medical personnel to engage in the practice of medicine or provide medical services or treatment without medical malpractice insurance.

21. Defendant St. Paul is the largest single carrier of medical malpractice insurance in the State of Rhode Island, insuring approximately six hundred (600) physicians, and numerous hospitals within the State, all of which is known and has been known to defendants Aetna, Travelers and Hartford.

22. Defendants St. Paul, Aetna, Travelers, and Hartford in the past had established a policy of accepting applications for medical malpractice insurance from any and all qualified physicians, hospitals or other medical personnel within the State.

23. Almost all current medical malpractice insurance policies written by defendant, St. Paul for physicians, hospitals and other medical personnel in the State of Rhode Island bear an expiration date of June 30, 1975, all of which is known, and has been known to defendants Aetna, Travelers and Hartford.

24. All medical malpractice insurance policies written by defendants, St. Paul, Aetna, Travelers, and Hartford in the State of Rhode Island and elsewhere throughout the United States have always been written on a so called "Occurrence Basis". ("Occurrence-type" insurance covers the insured provider of medical services for every claim that arises or might arise from any act done during the time when the insurance coverage was in force.)

25. Upon information and belief, all medical malpractice insurance written by each insurance carrier throughout the United States has always been written on a so called "Occurrence Basis".

26. Upon information and belief, no medical malpractice insurance has ever been written any where in the United States on a "Claims Made" basis.

27. "Claims Made" insurance purports to insure the medical service provider only on the basis of insuring against those claims which are actually made and filed during the year in which the insurance is in force and effect, without regard as to when the alleged act of malpractice occurred. Thus, a medical service provider would have to buy a minimum of four (4) one-year policies in order to have coverage comparable to an "occurrence-type" policy.

28. On or about April 18, 1975, defendant, St. Paul, notified plaintiff physicians that under no conditions would it renew any of its "occurrence-type" medical malpractice insurance policies then in force and due to expire on June

30, 1975, but that it would issue to its insured one (1) year medical malpractice policies on a "Claims Made" basis only.

29. In addition, said defendant, St. Paul, has notified certain hospitals insured by it that their medical malpractice insurance then in force and due to expire on June 30, 1975, would not be renewed under any conditions.

30. Upon information and belief, defendants Aetna, Travelers and Hartford, beginning on or about April 18, 1975, and continuing up to and including the present time, conspired with defendant, St. Paul, and engaged in a continuing unlawful combination and conspiracy, unreasonably to deny any medical malpractice insurance coverage on an "Occurrence Basis" to all of the physicians insured with defendant, St. Paul, at said time.

31. Upon information and belief, defendants Aetna, Travelers and Hartford, beginning on or about April 18, 1975, and continuing up to and including the present time, conspired with defendant, St. Paul, and engaged in a continuing unlawful combination and conspiracy, unreasonably to deny any medical malpractice insurance coverage on any basis to certain hospitals insured with defendant, St. Paul, at said time.

32. In furtherance of the aforesaid unlawful combination and conspiracy, defendants, Aetna, Travelers and Hartford have made and carried out the policy of refusing, and have refused from April 18, 1975, to the present time, to accept any applications for medical malpractice insur-

ance of any type from any physicians, hospitals or other medical personnel presently insured by defendant, St. Paul.

33. The aforesaid unlawful combination and conspiracy of said defendants has consisted of a continuing agreement and concert of action among the defendants, the effect of which has been to place the physicans and hospitals and other medical personnel insured by St. Paul in the State of Rhode Island in a dilemma, whereby they can purchase medical malpractice insurance from one insurer only, to wit defendant, St. Paul, and that purchase must be made on terms dictated by the defendant, St. Paul.

34. The aforesaid unlawful combination and conspiracy of said defendants has consisted of a continuing agreement and concert of action the object and result of which has been a stifling of competition in the medical malpractice insurance market in Rhode Island, has given an exclusive monopoly to defendant St. Paul for the sale of medical malpractice insurance over six hundred (600) physicians and numerous hospitals and has, in effect, threatened to deprive said six hundred (600) physicians and numerous hospitals of their right to acquire medical malpractice insurance on a reasonable basis, and thus their right to engage in the practice of medicine and to provide medical services, all for no justifiable business reason.

35. Defendant St. Paul, in concert with defendants, Aetna, Travelers, and Hartford has engaged in a purposeful course of coercion, intimidation, boycott and unfair competition with respect to the sale of medical malpractice insurance in the State of Rhode Island.

V

DAMAGES

36. As a result of the aforesaid actions of the defendants, the physicians of Rhode Island insured by defendant, St. Paul, have been placed in the position where they are unable to obtain medical malpractice insurance on a reasonable basis after June 30, 1975.

37. As a result of the aforesaid actions of the defendants, the physicians of the State of Rhode Island may be forced to withhold medical services and disengage from the practice of medicine, except on an emergency basis, as a result of which the plaintiff patients and prospective patients will be deprived of medical care and treatment; and the health, safety, welfare and lives of the citizens of Rhode Island will become endangered.

38. As a result of the aforesaid actions of the said defendants, if medical services of the physicians are withheld, the hospitals in the State of Rhode Island will encounter grave financial difficulty, and some of them are in danger of becoming insolvent.

39. As a result of the aforesaid actions of the defendants, the plaintiff physicians are being deprived of their right to practice their profession and to earn a living in the State of Rhode Island.

40. The aforesaid unlawful combination and conspiracy has consisted of a continuing agreement and concert of action among the defendant co-conspirators, the substantial terms and objects of which have included:

a. A collective refusal to deal with and insure on an occurrence basis over six hundred (600) physicians and numerous hospitals presently insured by defendant, St. Paul.

b. Boycott, coercion and intimidation resulting in or tending to result in an unreasonable restraint of or monopoly in, the business of insurance in the State of Rhode Island and unreasonable restraint or interference with the practice of medicine.

c. Unfair discrimination between individuals of the same class in the rates charged for contracts for medical malpractice insurance.

d. A concerted agreement not to compete with each other for medical malpractice insurance clientele in the State of Rhode Island.

e. Horizontal fixing of prices for medical malpractice insurance issued in the State of Rhode Island.

f. Unfair discrimination between individuals of the same class and of essentially the same risk in the amount of premium, policy fees or rates charged for policies of medical malpractice insurance.

41. As a result of the foregoing, the health, welfare and public interest, and in fact, the entire economy of the State of Rhode Island are gravely and seriously threatened.

42. By reason of the foregoing, plaintiff physicians will suffer great losses of revenue, plaintiff hospitals will suffer great loss of profits and plaintiff patients will be forced to

pay great sums of money in the form of increased rates for hospital and medical care and attention in the future.

WHEREFORE, plaintiffs demand:

1. That a temporary restraining order, a preliminary injunction and a permanent injunction issue out of this court restraining and enjoining the defendants, and each of them, and their agents, servants and employees from acting or to deny, refuse or interfere with the plaintiff physicians and hospitals in the purchase or acquisition of medical malpractice insurance on an "occurrence basis" at reasonable rates, and from acting in concert or combination in this regard.

2. That a temporary restraining order, a preliminary injunction and a permanent injunction issue out of this court restraining and enjoining the defendants, and each of them, and their agents, servants and employees from acting in concert or combination as follows, or having the following objectives:

a. A collective refusal to deal with and insure on an "occurrence basis" all physicians and hospitals presently insured by defendant St. Paul.

b. Boycott, coercion and intimidation resulting in or tending to result in an unreasonable restraint of or monopoly in, the business of insurance in the State of Rhode Island and unreasonable restraint of or interference with the practice of medicine.

c. Unfair discrimination between individuals of the same class in the rates charged for contracts for medical malpractice insurance.

d. A concerted agreement not to compete with each other for medical malpractice insurance clientele in the State of Rhode Island.

e. Horizontal fixing of prices for medical malpractice insurance issued in the state of Rhode Island.

f. Unfair discrimination between individuals of the same class and of essentially the same risk in the amount of premium, policy fees or rates charged for policies of medical malpractice insurance.

3. That a temporary restraining order, a preliminary injunction and a permanent injunction issue out of this court restraining and enjoining the defendants, and each of them, and their agents, servants and employees from acting in concert and combination to coerce, intimidate or compel plaintiffs to act in any given manner with reference to the purchase of medical malpractice insurance, including, without limiting the generality of the foregoing, coercing or compelling any plaintiff physician to purchase medical malpractice insurance solely from defendant St. Paul or any other defendant insurance company.

4. That a temporary restraining order, a preliminary injunction and a permanent injunction issue out of this court restraining and enjoining the defendants, and each of them, and their agents, servants and employees from entering into, adhering to renewing, maintaining or furthering directly or indirectly, any like or similar combinations and conspiracies to restraining trade and commerce in the sale of medical malpractice insurance in the state of Rhode Island as hereinbefore alleged.

5. That this court ascertain the damages suffered by plaintiffs by reason of the unlawful acts of the defendants herein complained of and award judgment in favor of the named plaintiffs, the members of the plaintiff classes and against the defendants, and each of them, for thrice the amount of said damages, costs and a reasonable attorneys' fee.

All to the damage of the plaintiffs in the sum of One Hundred Million Dollars ($100,000,000.00).

COUNT II

I

Jurisdiction

1. Jurisdiction is based upon diversity of citizenship of plaintiffs and defendants under the provisions of (28 U.S.C.A. §1332).

2. The matter in controversy exceeds the sum of Ten Thousand Dollars ($10,000.00) exclusive of interest and costs.

II

Parties

1-6. Paragraphs 1 through 6 of Section II of Count I are hereby incorporated by reference.

III

Cause of Action

7. Defendants St. Paul, Aetna, Travelers and Hartford since the inception of their offering medical malpractice insurance in the State of Rhode Island have been obligated and required by law to make certain disclosures of information regarding the operation and finances of their respective businesses, including, without limitation, with respect to the sale of medical malpractice insurance, the collection of premiums therefor, and the payment of claims.

8. On the basis of the aforesaid information furnished by the defendants to the Insurance Commissioner of the State of Rhode Island and to the plaintiffs, premium rates for medical malpractice insurance have been established.

9. On the basis of the aforesaid information furnished by said defendants, plaintiff physicians have, at all times herein mentioned, been paying premiums for medical malpractice insurance to said defendant companies.

10. Plaintiffs allege that defendants, and each of them, in violation of their obligations to plaintiffs and to the general public, fraudulently and deceitfully:

a. Failed to disclose material facts to the plaintiffs, the general public and the Insurance Commissioner of the State of Rhode Island.

b. Actively concealed material facts from the plaintiffs, the general public, and the Insurance Commissioner of the State of Rhode Island.

c. Furnished false information to the plaintiffs, to the general public and to the Insurance Commissioner of the State of Rhode Island.

d. Made material misrepresentations to the plaintiffs, to the general public and to the Insurance Commissioner of the State of Rhode Island.

11. Plaintiffs allege that defendants, and each of them, during the course of contract negotiations with plaintiff physicians for the purchase and sale of medical malpractice insurance for sale in the State of Rhode Island, fraudulently and deceitfully:

a. Failed to disclose material facts.

b. Actively concealed material facts.

c. Furnished false information.

d. Made material misrepresentations.

12. At all times herein mentioned, defendants, and each of them, knew or should have known of the falsity and misleading nature of the aforesaid information and misrepresentations.

13. Defendants, and each of them, made said false disclosure, concealed said information, and made said misrepresentations with the intent that the plaintiffs, the general public and the Insurance Commissioner of the State of Rhode Island be deceived thereby and rely thereon.

14. The plaintiffs at all times herein mentioned, have been unable to acquire the correct information concerning

such material facts, and until the filing of the within Complaint, have been ignorant of the true nature thereof.

15. Plaintiffs have at all times herein mentioned, relied on the aforesaid false information, and misrepresentations to their detriment.

16. As a direct result thereof, plaintiff physicians have, at all times herein mentioned, purchased medical malpractice insurance at premiums far in excess of the fair and justifiable rate which should have been charged them in accordance with current market conditions and the law.

17. As a direct result thereof, plaintiff patients have, at all times herein mentioned, been required to pay charges for medical treatment and hospitalization far in excess of fair and justifiable charges in accordance with the current market conditions, said excess charges being directly attributable to the unreasonably high premiums for medical malpractice insurance charged physicians and hospitals by said defendants as described herein.

WHEREFORE:

a. Plaintiff physicians demand that the defendants, and each of them, be ordered to make restitution to them of all premiums charged them in excess of the fair and justifiable rate which should have been charged from the inception of the offering and sale of medical malpractice insurance in the State of Rhode Island by the defendants to them.

b. Plaintiff patients demand that defendants, and each of them, be ordered to make full restitution to

them for all charges for medical attention and hospital care paid by them in excess of the fair and justifiable charges which should have been made, since the inception of the offering and sale of medical malpractice insurance by the defendants to physicians and hospitals in the State of Rhode Island.

c. Plaintiff physicians and patients demand that defendants, and each of them, be ordered to pay counsel fees, compensatory and punative damages in such sums as the court shall determine fair and justifiable.

COUNT III

I

Jurisdiction

1. Section I, Paragraphs 1 and 2 of Count II are hereby incorporated by reference.

II

Parties

1-6. Paragraphs 1 through 6 of Section II of Count I are hereby incorporated by reference.

III

Cause of Action

7-13. Paragraphs 7 through 13 of Section III of Count II are hereby incorporated by reference.

14. After making said false misrepresentations and disclosures, and fraudulently concealing said information, defendant St. Paul, announced that it would refuse to renew any of its policies of medical malpractice insurance for physicians commencing July 1, 1975 on any basis other than "claims-made", which they knew, or should have known, would be totally unacceptable to all their insured physicians.

15. Defendants, Aetna, Travelers and Hartford, at the same time, and thereafter, refused to offer medical malpractice insurance to any of defendant St. Paul's customers under any conditions whatsoever, thereby putting some six hundred (600) plaintiff physicians in a dilemma, wherein they could purchase medical malpractice insurance from St. Paul only, and then under conditions dictated by St. Paul; to wit, a "claims-made" basis.

16. The actions of defendants, and each of them, complained of in Counts I, II and III hereof, created a situation in the State of Rhode Island whereby the Governor, in order to provide medical malpractice insurance for physicians and assure the availability of health services to the citizens of the State of Rhode Island, including, but not limited to the class of plaintiff patients, was obligated to establish a joint underwriting association through which all physicians in the State of Rhode Island are obligated by law to purchase their medical malpractice insurance.

17. Upon information and belief, the rates for said medical malpractice insurance under said joint under-

writing authority will be substantially in excess of the rates previously paid by plaintiff physicians and of the rates which should have been paid by plaintiff physicians in the absence of misrepresentations, fraudulent conduct and other acts of defendants as complained of in Counts I, II, and III.

18. As a direct result thereof, plaintiff patients will be forced to incur expenses for medical services and hospitalization far in excess of what they should be charged in the absence of misrepresentations, fraudulent conduct and other acts of defendants as complained of in Counts I, II, and III.

WHEREFORE, plaintiff physicians and plaintiff patients demand that damages be assessed against the defendants, and each of them, to include compensatory damages, punitive damages and reasonable attorneys fees.

COUNT IV

I

JURISDICTION

1. Section I, Paragraphs 1 and 2 of Count II are hereby incorporated by reference.

II

PARTIES

1-6. Paragraphs 1 through 6 of Section II of Count I are hereby incorporated by reference.

III

CAUSE OF ACTION

7-15. Paragraphs 7 through 15 of Section III of Count II are hereby incorporated by reference.

16. The defendants, and each of them, misled plaintiff physicians into believing that medical malpractice insurance was not obtainable in the State of Rhode Island at the maximum rates established by the Insurance Commissioner of the State of Rhode Island, and fraudulently and deceitfully coerced certain of plaintiff physicians into purchasing medical malpractice insurance from said defendants at rates in excess of the maximum rates established by the Insurance Commissioner of the State of Rhode Island. In furtherance of such fraudulent scheme, defendants require that the plaintiff physicians purchasing said insurance at rates in excess of the maximum rates established by the Insurance Commissioner of the State of Rhode Island, sign a so-called "waiver form" devised and provided by defendants wherein the purchaser purports to represent to the selling insurance company that the insurance coverage that he desires to purchase is unavailable in the State of Rhode Island at rates at the maximum rate established by the Insurance Commissioner, and the purchaser therefore requests that the insurance company sell him such coverage at rates in excess of the maximum so established.

17. As a direct result thereof, defendants have sold to some of plaintiff physicians medical malpractice insurance at rates in excess of the maximum rates established

by the Insurance Commissioner of the State of Rhode Island, in contravention of the laws of the State of Rhode Island.

18. The defendants, and each of them, have, by coercion, intimidation, fraud, deceit and other actions complained of, supra, forced plaintiff physicians to enter into unconscionable contracts of insurance, in violation of the law and public policy.

19. As a direct result thereof, plaintiff physicians have been forced to expend unjustified and exhorbitant amounts for the purchase of medical malpractice insurance.

20. As a direct result thereof, patients have been, and will in the future be required to pay charges for medical treatment and hospitalization far in excess of the fair and justifiable charges in accordance with the then current market conditions.

WHEREFORE, plaintiff physicians and plaintiff patients demand that damages be assessed against the defendants, and each of them, to include compensatory damages, punitive damages and reasonable attorneys fees.

All to the damage of the plaintiffs in the sum of One Hundred Million Dollars ($100,000,000.00).

By their Attorney:

/s/ LEONARD DECOF

LEONARD DECOF
Leonard Decof, Ltd.
111 Wayland Avenue
Providence, Rhode Island 02906

Opinion of the District Court of the United States for the District of Rhode Island

DISTRICT COURT OF THE UNITED STATES
FOR THE DISTRICT OF RHODE ISLAND

Civil Action No. 75-176

DAVID M. BARRY, M. D. *et al.*

v.

ST. PAUL FIRE & MARINE INSURANCE COMPANY, *et al.*

OPINION

(Rendered orally from the bench November 19, 1975)

PETTINE, Chief Judge. This is a class action brought on behalf of practicing physicians licensed to practice medicine in the State of Rhode Island and on behalf of citizens of Rhode Island who are presently under the care of physicians or who may require medical care in the future. The action is brought against four insurance companies, licensed to sell insurance in the State of Rhode Island, who are, and have been, engaged in selling medical malpractice insurance to physicians, hospitals, and other medical personnel in Rhode Island. The plaintiffs' amended

complaint alleges, in essence, that the four defendants have conspired to monopolize the business of selling medical malpractice in Rhode Island and, in violation of both federal antitrust law and state common law have, through various unfair trade practices and fraudulent misrepresentations, obtained the approval by the State Insurance Commissioner of excessive medical malpractice premium rates and have thereby been unjustly enriched at the plaintiffs' expense. Plaintiffs seek injunctive relief and $100,000,000 in damages. The case is presently before the Court on several motions by the defendants for dismissal on various grounds of all four counts of the complaint and for summary judgment on one of the counts.

I. COUNT I

Count I of the plaintiffs' amended complaint purports to set forth a private action under the federal antitrust laws. The gravaman of Count I is that the four defendant insurance companies violated sections 1 and 2 of the Sherman Act by conspiring to deny any medical malpractice insurance coverage on an occurrence basis to providers of medical services insured under malpractice policies issued by defendant St. Paul and by conspiring that defendants Aetna, Travelers, and Hartford would refuse to accept any applications for medical malpractice insurance of any type from providers presently insured by St. Paul. Plaintiffs contend that these conspiracies have been effectuated by a collective refusal to deal, by unfair insurance rate discrimination, by agreements not to compete, and by horizontal price fixing, and that the defendants have engaged in a

purposeful course of coercion, intimidation, boycott, and unfair competition with respect to the sale of medical malpractice insurance in Rhode Island.

All four defendants have moved that Count I be dismissed under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim upon which relief can be granted on the grounds that plaintiffs' claims under the Antitrust Acts are barred by the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015, which allegedly exempts the defendants' challenged activities from the Antitrust Acts. In addition, three defendants have also argued that Count I should be dismissed because events occurring subsequent to the events alleged in Count I have rendered plaintiffs' action moot. The Court need not reach this mootness question because I find that Count I of the plaintiffs' amended complaint is barred by the McCarran Act.

The McCarran Act provides in pertinent part:

> "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948 . . . the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act, . . . shall be applicable to the business of insurance to the extent that such business is not regulated by state law."
> 15 U.S.C. §1012(b).

The Act also contains the following exception:

> "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to

> boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."
> 15 U.S.C. §1013(b).

It is not contested that the subject of this action is the "business of insurance." This case involves the relations between the defendant insurers and the insured physicians and hospitals,[1] the types and terms of the policies that are or that plaintiffs claim ought to be sold, and the rates to be charged therefor. These matters are precisely those aspects of the business of insurance Congress was considering in the McCarran Act:

> "Congress was concerned with the type of state regulation that centers around the contract of insurance . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.' . . . [I]t is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.' "
> *S.E.C.* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Nor is it contested that the business of insurance is extensively regulated by the State of Rhode Island. For example, every foreign insurance company must obtain a license from the Insurance Commissioner each year before it

1. Although none of the named plaintiffs are hospitals, plaintiffs apparently consider hospitals in Rhode Island to be a part of the plaintiff class. All questions relating to class certification have been deferred until after resolution of the present motions.

can transact business in Rhode Island, R.I. Gen. Laws §27-2-11, and premium rates may not be excessive or unfairly discriminatory, R.I. Gen. Laws §27-9-4. Moreover, chapter 27-29 of Rhode Island's General Laws, entitled "Unfair Competition and Practices" was enacted with the explicit purpose of regulating the very misconduct and practices that, but for the McCarran Act, would be controlled by federal antitrust laws:

> "The purpose of this Chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of congress of March 9, 1945 (public law 15, 79th congress) [i.e., the McCarran Act] by defining—or providing for the determination of—all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined and determined."
> R.I. Gen. Laws §27-29-1.

In addition, the area of medical malpractice insurance has been singled out for more particular state regulation and control by Emergency Regulation XXI, issued by the Rhode Island Director of Business Regulation, Insurance Division, which went into effect on June 16, 1975.[2]

Since the defendants' alleged misconduct involves aspects of the insurance business regulated by state law, the

2. Under the Emergency Regulation was created the Medical Malpractice Joint Underwriting Association of Rhode Island, which represents a new and comprehensive program for the provision of medical malpractice insurance in Rhode Island. Under the program, every insurer authorized to write personal injury liability insurance in Rhode Island is required to participate in the Association and to assist in the provision of medical malpractice insurance to providers of medical services in Rhode Island.

plaintiffs' private antitrust action is barred by the McCarran Act unless it falls within the exception for boycotts, coercion, or intimidation, 15 U.S.C. §1013(b), quoted *supra*. This Court is persuaded that, despite this provision's broad wording, which on first glance seems to support the plaintiffs' position, Congress intended this exception to be narrowly applied and that it does not, in fact, cover the situation presented in this case.

Both Courts of Appeals that have considered similar attempts to invoke the exception in 15 U.S.C. §1013(b) have concluded that such an application of the exception would be contrary to the legislative history of the Act and would "emasculate" and "vitiate" the Act and frustrate its purposes. *Meicler* v. *Aetna Casualty & Surety Co.*, 506 F.2d 732 (5th Cir. 1975); *Addrisi* v. *Equitable Life Assurance Society of the United States*, 503 F.2d 725 (9th Cir. 1974). *See also Transnational Insurance Co.* v. *Rosenlund*, 261 F.Supp. 12 (D.Ore. 1966). These cases hold that the purpose of the boycott, coercion, and intimidation exception was solely to protect insurance agents or other insurance companies from being "black-listed" by powerful combinations of insurance companies, not to affect the insurer-insured relationship. Thus, the District Court in *Meicler*, *supra*, explained:

> "This Court is convinced that Plaintiffs' reliance on §1013(b) is misplaced. It cannot be disputed that the terms boycott and coercion, as commonly defined, might be construed to encompass the type of activity attributed to Defendants in the instant case. An examination of the legislative history of this section reveals, however, that Congress was seeking to regulate a rather narrow area of activity bearing no resemblance to the situation described in Plaintiffs' Complaint. Section 1013(b) was designed primarily to deal with conspiracies or combinations among insurance companies and agents for the purpose of boycotting or refusing to deal with other insurance companies and agents. There is nothing in the legislative history or case law bearing on this section to indicate that it is applicable to a refusal by insurance companies to deal with particular segments of the public except under fixed classifications and premium rates."
> 372 F.Supp. 509, 513-14 (S.D. Tex. 1974).

"[T]o hold otherwise," wrote the Ninth Circuit in *Addrisi*, *supra*, "would vitiate the McCarran-Ferguson Act in its concept of setting over unto the several states the regulation, and protection of the insurer-insured relationship." 503 F.2d at 729.

This Court agrees with the interpretation of the legislative history of 15 U.S.C. §1013(b) presented in the *Meicler*, *Addrisi*, and *Rosenlund* decisions, *supra*, and adopts it as its own. Plaintiffs have failed to uncover any portion of the legislative history that would justify a contrary conclusion. The plaintiffs do cite and heavily rely upon the case of *Battle* v. *Liberty Nat'l Ins. Co.*, 493 F.2d 39 (5th Cir. 1974), *rehearing denied*, 503 F.2d 567, *cert. denied*, 419 U.S. 1110 (1975), however, contending that *Battle* stands for the proposition that §1013(b) can be applied to protect consumers as well as insurance companies and agents. The plaintiffs in *Battle*, however, were not insurance policyholders but rather business representatives of the insurance companies sued:

> "The plaintiffs in this class action are funeral homes and directors of funeral homes who allege that the de-

> fendants [insurance companies] are liable to them for violating the antitrust laws. . . . When the funeral home director signs a contract with [insurance companies], his funeral home becomes an 'authorized home for *servicing and furnishing merchandise to Liberty National burial insurance policyholders'.*" 393 F.2d at 42, 43. (emphasis added).

Thus, individual insureds were not parties to the action, and no exception to the McCarran Act was claimed for them. Furthermore, it should be noted that *Battle* was decided by the Fifth Circuit before it decided *Meicler* v. *Aetna Casualty & Surety Co., supra.* To the extent there is any inconsistency between the two cases, *Meicler* must be read as implicitly overruling *Battle.*

Plaintiffs in this case are individual insureds and their antitrust claims are thus not exempted by section 1013(b) from the limitations of the McCarran Act. Count I of plaintiffs' amended complaint is therefore dismissed.

II. COUNTS II, III, and IV

Count II of the plaintiffs' amended complaint is a diversity action based on the claim that the premium rates charged by the defendants for their malpractice insurance, as approved by the Rhode Island Insurance Commissioner, were excessive and were obtained by fraudulently concealing material facts, furnishing false information, and making material misrepresentations. Counts III and IV, also diversity actions are based on the conduct set forth in Counts I and II and allege that as a result of the defendants' fraudulent acts, Rhode Island was forced to create

a state agency to underwrite medical malpractice insurance that charges excessive premium rates, and certain plaintiff physicians were induced to purchase malpractice insurance at rates in excess of the maximum rates established by the Rhode Island Insurance Commissioner.

All the defendants have moved that Counts II, III, and IV of the amended complaint should be dismissed on the grounds that the allegations of fraud contained therein have failed to satisfy the special pleading requirements of Federal Rule of Civil Procedure 9(b). In addition, three of the defendants have moved that Counts II and III should be dismissed because plaintiffs failed to exhaust their state administrative remedies, or, in the alternative, that the Court exercise its discretion to abstain from exercising jurisdiction over these counts. These defendants have also moved for summary judgment in their favor on Count IV on the grounds that none of the named plaintiffs have any complaints against these defendants on the grounds alleged in Count IV and they therefore lack standing to bring the claims set forth in Count IV and are not members of the class they seek to represent.

The Court need not reach these questions, however, because it appears on consideration of a motion by defendant Travelers that this Court lacks jurisdiction to entertain any of the claims plaintiffs put forth in Counts II, III, and IV. As indicated *supra,* these three counts are all premised on diversity jurisdiction under 28 U.S.C. §1332. There is evidence before the Court, however, in the form of a communication from the Department of State of the State of Rhode Island, that defendant Travelers Indemnity Company of Rhode Island is a Rhode

Island Corporation. Since the named plaintiffs are all citizens of Rhode Island, there is a lack of complete diversity between all the plaintiffs on the one hand and all the defendants on the other, and thus under the well established rule there is no basis for the exercise of federal diversity jurisdiction. *Smith* v. *Sperling*, 354 U.S. 91 (1957); *Strawbridge* v. *Curtiss*, 3 Cranch. (7 U.S.) 267 (1806).[3]

Moreover, this it not an appropriate case for the Court to take pendent jurisdiction over Counts II, III, and IV. Even where the federal claim to which the state claims are to be appended is a substantial one, "pendent jurisdiction is a doctrine of discretion, not of plaintiffs' right. . . ." *United Mine Workers of America* v. *Gibbs*, 383 U.S. 715, 726 (1965). The policies underlying pendent jurisdiction are less significant when the federal claim is a weak one, and the Supreme Court has stated flatly that "if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well." *Id.* Although the Court has since retreated somewhat from this hard and fast rule, in *Rosado* v. *Wyman*, 397 U.S. 397, 404 (1970), where substantial time and energy had been expended toward resolution of the state claim, such considerations are not present here. This litigation is less than six months old, and all discovery has been stayed pending resolution of the present motions. In the words of the American Law Institute:

3. There is no basis in this case for a realignment of the parties, such as occurred in *Broidy* v. *State Mut. Life Assur. Co. of Worcester, Mass.*, 186 F.2d 490 (1951) or *Robinson* v. *Warner*, C.A. No. 5253 (D.R.I. 1973), that could sustain diversity jurisdiction.

> "If the federal element that is the basis for jurisdiction is disposed of early in the case, as on the pleadings, it smacks of the tail wagging the dog to continue with a federal hearing of the state claim."
>
> American Law Institute, Study of the Division of Jurisdiction between State and Federal Courts, Official Draft, 1969, at 213, quoted in *McFadden Express, Inc.* v. *Adley Corp.*, 346 F.2d 424, 427 (2d Cir. 1965), *cert. denied* 382 U.S. 1026.

A further reason for refusing pendent jurisdiction in this case is the Supreme Court's admonition that federal courts avoid needless decisions of state law, "both as a matter of comity and to promote justice between the parties, by procuring for them a surer-footed reading of applicable law." *United Mine Workers of America* v. *Gibbs, supra*, 383 U.S. at 726. It is clear from the defendants' motions to dismiss Counts II, III, and IV on grounds other than lack of jurisdiction that the ultimate resolution of the plaintiffs' claims in this case would require explorations of several novel questions of state law, such as whether the administrative remedies provided by Rhode Island's statutes regulating the insurance industry were intended by the state legislature to totally preempt any common law causes of action which may have existed for recovering excessive insurance premiums.[4] It is also

4. In *Catalano* v. *Department of Hospitals of the City of New York*, 299 F.Supp. 166, 175 (S.D.N.Y. 1969), the Court refused to exercise pendent jurisdiction over a claim turning on the construction of a New York Social Services law on the grounds that the claim "presents a question of state legislative intent and delegation of powers to an administrative body, which more appropriately lies within the ambit of the state court's expertise with respect to its own laws."

noteworthy that the problem of medical malpractice insurance is currently the subject of intense public debate in Rhode Island, and the state government has recently taken major affirmative steps to come to grips with the problems in this area. These factors alone, of course, would not preclude this Court from taking pendent jurisdiction over Counts II, III, and IV, but when they are considered in light of the dismissal of the federal claim, the early stage of this litigation, and the complex questions of state law that are presented, I conclude that it would verge on an abuse of my discretion to exercise pendent jurisdiction in this case.

All four counts of the plaintiffs' amended complaint are hereby dismissed

/s/ RAYMOND J. PETTINE

Chief Judge

Nov. 25, 1975

Opinion of the United States Court of Appeals for the First Circuit

UNITED STATES COURT OF APPEALS

FOR THE FIRST CIRCUIT

No. 76-1226

DAVID M. BARRY, M.D., ET AL.,
PLAINTIFFS, APPELLANTS,

v.

ST. PAUL FIRE &
MARINE INSURANCE COMPANY, ET AL.,
DEFENDANTS, APPELLEES.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

[HON. RAYMOND J. PETTINE, *U.S. District Judge*]

Before COFFIN, *Chief Judge*
CAMPBELL, *Circuit Judge*, and
GIGNOUX,* *District Judge*.

Leonard Decof, with whom *Mark S. Mandell* and *Leonard Decof, Ltd.* were on brief, for appellants.

Sidney S. Rosdeitcher, with whom *Paul, Weiss, Rifkind, Wharton & Garrison, Jack Hassid, Hinckley, Allen, Salisbury & Parsons, Thomas D. Gidley, Stephen J. Carlotti, Covington & Burling, Charles Lister, Jonathan M. Weisgall, Carroll, Kelly & Murphy*, and *Joseph A. Kelly* were on brief, for Aetna Casualty & Surety Co., Hartford Casualty Company and Hartford Fire Insurance Company, appellees.

Walker B. Comegys, with whom *Powers & Hall, Kirk Hanson, David P. Whitman, Hanson, Curran, Bowen & Parks, Joseph V. Cavanagh*, and *Higgins, Cavanagh & Cooney* were on brief, for St. Paul Fire & Marine Insurance Company and Travelers Insurance Company, appellees.

* Of the District of Maine, sitting by designation.

May 16, 1977

COFFIN, *Chief Judge.* The primary issue presented by this appeal is whether a "consumer" of insurance can sue an insurance company for violating the antitrust laws. Under the McCarran-Ferguson Act, 15 U.S.C. §§1011-15, "the business of insurance" is exempted from antitrust regulation to the extent that it is regulated by the states. *Id.* §1012(b). But McCarran-Ferguson does not confer a blanket immunity: insurers are subject to the Sherman Act if they engage in "acts of boycott, coercion, or intimidation" or if they agree to engage in such acts. *Id.* §1013(b). We must decide whether this exception applies only to insurance company boycotts of agents and other companies or also applies to refusals to deal with policyholders.

This suit is brought by plaintiffs seeking to represent two classes: all licensed physicians practicing in the state of Rhode Island and all citizens of Rhode Island who are or will be under a doctor's care. The defendants are four insurance companies that have sold malpractice insurance to Rhode Island doctors. The plaintiffs charges in their amended complaint that these companies violated the nation's antitrust laws by conspiring to shrink the malpractice coverage available to Rhode Island doctors. According to the complaint, one company, St. Paul Fire & Marine Insurance Company, changed its future malpractice policies to provide coverage only on a "claims made" basis, rather than an "occurrence"

basis.[1] When St. Paul's disgruntled customers tried to take their business elsewhere, the other insurance companies refused to sell them malpractice policies of any sort. Believing this to be the result of an unlawful conspiracy in restraint of trade, plaintiffs sought injunctive relief and treble damages.[2] The viability of their suit depends on the scope of the McCarran-Ferguson Act. 15 U.S.C. §1011-15.

The Act must be placed in historical context if it is to be understood. For many years, from 1869 to 1944, the Supreme Court steadfastly maintained that insurance was not "commerce" and that state regulation of insurance did not impinge on the federal government's power to regulate interstate commerce. *See, e.g., Paul* v. *Virginia,* 75 U.S. (8 Wall.) 168 (1869). In 1944, however, the Supreme Court repudiated the principle that insurance is not commerce and held that federal antitrust laws could constitutionally be applied to insurance companies. *United States* v. *South-Eastern Underwriters Ass'n,* 322

1. An "occurrence" policy protects the holder from liability for any act done while the policy is in effect; a "claims made" policy, in contrast, protects the holder only against claims made during the policy's life. Thus a doctor who practiced for only one year, say 1972, would need only one 1972 "occurrence" policy to be fully covered, but he would need several years of "claims made" policies to protect himself from claims arising out of his acts in 1972.

2. At our request, both sides briefed the question of whether the plaintiffs' antitrust claim was mooted when the state of Rhode Island formed a joint underwriting association to provide malpractice insurance. Because of the state's action, St. Paul never gathered the fruits of the alleged conspiracy. Nonetheless, we are convinced that, for purposes of our jurisdiction, the state's act did not extinguish plaintiffs' every claim for relief. *United States* v. *Concentrated Phosphate Export Ass'n, Inc.,* 393 U. S. 199, 203-04 (1968). We do not decide whether plaintiffs were in fact "injured in [their] business or property". 15 U.S.C. §15. *Cf.* n.7 *infra.* Nor do we decide whether this would be an appropriate case for injunctive relief.

U.S. 533 (1944). This decision left the nation's insurance companies and the states' regulatory bodies dumbfounded; suddenly, state taxation and regulation of insurance seemed open to serious constitutional doubts. Federal authorities were loath to assume the burden of substituting national for state supervision of insurance.

To restore some certainty, Congress passed the McCarran-Ferguson Act in 1945. The Act made it clear that state regulation and taxation of insurance could continue. It also narrowed the impact of federal law on the insurance business, stating that "the Sherman Act, . . . the Clayton Act, and . . . the Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. §1012(b). This provision allows the states to engage in a kind of "reverse preemption", and the states were quick to enact the necessary laws.

The parties agree that the defendants' acts were related to the business of insurance and that Rhode Island effectively regulates that business. *Cf. SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969); *FTC* v. *Travelers Health Ass'n*, 362 U.S. 293 (1960). The controversy in this case centers on an exception to the "preemptive" powers of the states: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." 15 U.S.C. §1013(b).

The district court concluded that "despite this provision's board wording, which on first glance seems to support the plaintiffs' position, Congress intended this exception to be narrowly applied and that it does not, in fact, cover the situation presented in this case." It held

that the "boycott, coercion, and intimidation" exception was intended by Congress solely to protect insurance agents or other insurance companies from being blacklisted by combinations of companies, and was not intended to have any bearing on the insurer-insured relationship. It also observed that a contrary holding would vitiate the McCarran-Ferguson Act by, presumably, cutting deeply into the area of regulation which has been given to the states. In so holding, it relied on the only case authorities which had dealt with this issue. *Addrisi* v. *Equitable Life Assurance Soc'y*, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *Meicler* v. *Aetna Cas. & Sur. Co.*, 506 F.2d 732 (5th Cir. 1975); *Transnational Ins. Co.* v. *Rosenlund*, 261 F. Supp. 12 (D. Ore. 1966).

Six other district courts have now taken the same view. *Mathis* v. *Automobile Club Inter-Ins. Exch.*, 410 F. Supp. 1037 (W.D. Mo. 1976); *Proctor* v. *State Farm Mut. Auto. Ins. Co.*, 406 F. Supp. 27 (D. D.C. 1975); *McIlhenny* v. *American Tit. Ins. Co.*, 418 F. Supp. 364 (E.D. Pa. 1976); *Royal Drug Co.* v. *Group Life and Health Ins. Co.*, 415 F. Supp. 343 (W.D. Tex. 1976); *Seasongood* v. *K & K Ins. Ag'cy*, 414 F. Supp. 698 (E.D. Mo. 1976), *rev'd on other grounds*, —— F.2d —— (8th Cir. Jan. 6, 1977); *Frankford Hosp.* v. *Blue Cross*, 1976-2 Trade Cas. ¶61,030 (E.D. Pa. 1976).[3]

3. In attacking the district court's decision, appellants cite an additional case from the Fifth Circuit. *Battle* v. *Liberty Nat'l Life Ins. Co.*, 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975). Although appellees correctly point out that *Battle* is distinguishable and that it was decided before *Meicler, supra*, the *Battle* court did show a willingness to give the boycott provision a straightforward reading, an attitude that we share. *See also Ballard* v. *Blue Shield*, 543 F.2d 1075, 1078 (4th Cir. 1976), *cert. denied*, 45 U.S.L.W. 3601 (Mar. 8, 1977).

Since we feel compelled to disagree with this rather formidable array of authorities, we first try to summarize as fairly as we can the bases for their decision. We then make our own analysis of the wording of the statute and its legislative history. The line of cases begins with *Transnational Ins. Co.* v. *Rosenlund, supra.* Although the *Transnational* court found that it was not faced with a boycott even within the ordinary meaning of that word, it announced in passing that the boycott provision

> "was placed in the legislation to protect insurance agents from the issuance by insurance companies of a 'black-list,' which would name companies or agents which were beyond the *pale*. This list, in effect, was a directive to an agent not to write insurance in the name of or for the black-listed companies; otherwise, he would be stripped of his agency and not permitted to write insurance for any of the members of the governing organization of insurance companies." 261 F. Supp. at 26-27 [footnote omitted].

Only blacklisting by an insurance company, the court intimated, was subject to the Sherman Act under this provision. The court, though referring broadly to "the legislative history", cited only a single page of the Congressional record in support of this reading. 91 Cong. Rec. 1087 (1945). *Transnational* stood alone until 1974, when the Fifth and Ninth Circuits followed its lead. The courts of appeals simply adopted without elaboration the *Transnational* court's discussion of "the" legislative history. One reason for taking so narrow a view of the provision was the courts' apparent fear that any other reading would "emasculate", *Meicler, supra,* 506 F.2d at 734, or "vitiate",

Addrisi, supra, 503 F.2d at 729, the McCarran-Ferguson Act. To fend off this danger, the *Meicler* court adopted a rule that policyholders or members of the public could not seek the benefit of the boycott provision. Later cases have followed these pioneers without adding to their analysis.

As will be seen, we disagree with the conclusion reached by these courts. Simple disagreement might not be enough if the insurance business had long relied on authoritative rulings in other circuits. That is not the case here. The view we reject was not advanced until 1966, when a single district court suggested it. Only in the past three years has its narrow reading of the boycott provision begun to gain more general favor. What prevents us from following the trail blazed by the *Transnational* court is its decision to go behind the statutory language. We would be justified in probing legislative history if the language were ambiguous or if, even though unambiguous, the language literally read produced a senseless or unworkable statute. *Massachusetts Financial Serv., Inc.* v. *Securities Investor Protection Corp.,* 545 F.2d 754 (1st Cir. 1976). *Cf. United States* v. *Slater,* —— F.2d —— (1st Cir. Dec. 22, 1976).

The words "agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation", within the context of the Sherman Act, do not appear to us as ambiguous. In antitrust law, a boycott is a "concerted refusal to deal" with a disfavored purchaser or seller. *Klor's, Inc.* v. *Broadway-Hale Stores, Inc.,* 359 U.S. 207 (1959).[4]

4. Most cases have dealt with boycotts directed against retailers or other links in the chain of production and distribution. *E.g., Fashion Originators' Guild of America, Inc.* v. *FTC,* 312 U.S. 457 (1941); *Radiant Burners, Inc.* v. *Peoples Gas Light and Coke Co.,*

(footnote continued on next page)

Concerted refusals by a number of companies to sell malpractice insurance policies to doctors who were dissatisfied with the policy offered by their insurer would seem to fit within this definition of boycott. Indeed appellees make no argument to the contrary. Nor do the cases attempt to justify their excursion into legislative history on the basis of ambiguity of language.

The articulated justification is based on the supposed "vitiation" of the McCarran-Ferguson Act if the boycott provision were to be given its normal Sherman Act scope. We observe first that a license to construe statutory words narrowly to avoid defeating legislative purpose is not to be cavalierly exercised. Under the McCarran-Ferguson Act,

364 U.S. 656 (1961). Consumers have less frequently been prey to illegal boycotts, perhaps because a large class of victims cannot easily be coerced without destroying the secrecy on which illegal boycotts often depend. But the features that make boycotts objectionable do not disappear when consumers are boycotted. Like boycotts aimed at retailers, concerted refusals to deal with consumers may restrain traders' "ability to sell in accordance with their own judgment"; they can deprive consumers of the "freedom to buy . . . in an open competitive market"; and they "interfere with the natural flow of interstate commerce". *See Klor's, Inc.* v. *Broadway-Hale Stores, Inc., supra,* 359 U.S. at 212-13. The Ninth Circuit has held that a boycott of customers is a boycott for antitrust purposes. *Washington State Bowling Proprietors Ass'n* v. *Pacific Lanes, Inc.,* 356 F.2d 371, 376 (9th Cir.), *cert. denied,* 384 U.S. 963 (1966).

Some commentators would artificially restrict the meaning of "boycott", apparently fearing an overbroad application of the rule that boycotts are illegal per se. *See* L. Sullivan, *Antitrust* §§83, 90 (1977). This fear may be allayed more directly by recognizing that, while some boycotts are irredeemably anticompetitive and thus fit subjects for a per se rule, others are benign and not properly treated as illegal per se. *See* P. Areeda, *Antitrust Analysis* 287 (1967); *see also Joseph E. Seagram & Sons, Inc.* v. *Hawaiian Oke & Liquors, Ltd.,* 416 F.2d 71 (9th Cir. 1969) (boycott not illegal per se when participants had no anti-competitive motive). Certainly nothing in this opinion requires the application of a per se rule to all acts falling within the ordinary meaning of the word "boycott".

states were given authority to tax and regulate the business of insurance. This domain remains a vast one even if the boycott provision is read more broadly than appellees insist. McCarran-Ferguson would still insulate state tax and regulatory programs from challenges based on the dormant commerce clause. *See Prudential Ins. Co.* v. *Benjamin,* 328 U.S. 408 (1946). It would continue to protect the business of insurance from many federal regulatory statutes. *See, e.g., SEC* v. *National Securities, Inc., supra* (securities laws). Even within the antitrust field, McCarran-Ferguson would have great significance. Only the Sherman Act is made applicable to the business of insurance by the boycott provision; the Clayton and Federal Trade Commission Acts, for example, could still be "preempted" by state regulation. Moreover, not every violation of the Sherman Act can be characterized as an act of boycott, coercion, or intimidation. *See, e.g., United States* v. *Aluminum Co. of America,* 148 F.2d 416 (2d Cir. 1945) (use of "benign" means to maintain monopoly violates Sherman Act); *Standard Oil Co.* v. *United States,* 221 U.S. 1, 43 (1911) (predatory pricing).

Nor would the introduction of antitrust principles into dealings between policyholders and insurers hamstring the state regulatory bodies that have primary responsibility for overseeing the nation's insurance business. A necessary regulatory measure could seldom be successfully challenged as a state-inspired "boycott, coercion, or intimidation", for the boycott provision merely guarantees that "[n]othing in *this chapter* shall render the Sherman Act inapplicable" to boycotts and the like. 15 U.S.C. §1013(b) [emphasis

added]. The chapter in question is the McCarran-Ferguson Act. The boycott provision merely neutralizes that Act, leaving intact the doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1943), which today insulates state regulatory schemes outside the insurance context from antitrust liability. *See also Cantor* v. *Detroit Edison Co.*, —— U.S. —— (July 6, 1976). Indeed, *Parker* v. *Brown* may have added strength in the insurance field because of the policies reflected in the McCarran-Ferguson Act. But there is a large difference between allowing a state to fix insurance rates without fear of antitrust sanctions and similarly insulating companies which, outside any state-permitted structure or procedure, agree among themselves that customers dissatisfied with the coverage offered by one company shall not be sold any policies by any of the other companies. Contrary to the argument of some of the appellees, giving normal scope to the boycott provision will not plunge federal courts into the enterprise of retroactive rate-making. Regulation by the state would be protected; concerted boycotts against groups of consumers not resting on state authority would have no immunity.

When we look to public policy, the limitation sought by appellees again lacks support. Throughout this century, preserving competition by means of the antitrust laws has been a continuing national purpose. A primary aim of antitrust law is assuring consumers the benefits of a free market economy. To exclude consumers of insurance from the protection afforded by the boycott provision thus cuts against a basic policy of antitrust law. Such an interpretation also conflicts with the Supreme Court's view that the McCarran-Ferguson Act as a whole is meant to apply to

the relationship between policyholders and their insurers. *SEC* v. *National Securities, Inc., supra,* 393 U.S. at 460. The boycott provision presumably also reflects this concern for the insurer-insured relationship. On a broader scale, we note that legislative and judicial exceptions to the general rule favoring free competition have often been narrowed over the years. *See, e.g., Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (July 6, 1976) ("state action" exception restricted); *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 785-88 (1975) ("learned profession" exception questioned); *United States* v. *International Boxing Club of New York, Inc.,* 348 U.S. 236 (1955) (refusing to extend "baseball" exemption to boxing); *Schwegmann Bros.* v. *Calvert Distillers Corp.,* 341 U.S. 384 (1951) (narrow view of Miller-Tydings "fair trade" exception). The McCarran-Ferguson Act is of course a legislative exception to the antitrust laws, and it deserves a fair reading.[5] But the artificial reading of the boycott provision that appellees urge on us can only be characterized as a judge-made expansion of the Act. We think the national commitment to a free market places a special burden on courts to think long and hard before creating such exceptions to the antitrust laws. In short, the usual reading of "boycott, coercion, or intimidation"

5. We cannot ignore, however, the great haste with which the Act was drafted and passed. The provision that all now agree is central to the Act—the exception of insurance to the extent that it is regulated by state law—did not appear in the Act until it was inserted by the House and Senate conferees. *See* 91 Cong. Rec. 488 (1945); *id.* 1945; *id.* 1396. Only at the last moment did a measure that was intended originally as a three-year moratorium on Sherman and Clayton Act coverage become a lasting exemption. This change was not noted in the conference report or the statement of the House conferees, *id.*, although it was uncovered by Senator Pepper in the floor debates. *Id.* at 1478.

does not lead to irrationality, nor does it pose a grave danger to state authority. It conforms to the nation's antitrust policies. We see no reason, therefore, to look to the legislative history for a special and narrow meaning of these words.

Nevertheless, in deference to the courts which have found support in that history, we have studied it in detail. The decision in *South-Eastern Underwriters, supra,* was issued on June 5, 1944. That decision approved an indictment charging that the members of an insurance underwriters' association "not only fixed premium rates and agents' commissions, but employed boycotts together with other types of coercion and intimidation to force nonmember insurance companies into the conspiracies, and to compel persons who needed insurance to buy only from [association] members on [association] terms." 322 U.S. at 535. Following that decision, an intensive several-month period of discussion produced a compromise measure agreed to generally by the insurance industry. The right of states to collect taxes from insurance companies had been put in doubt; the states' tax collecting effort would normally take place between February 20 and March 10, 1945. Thus legislative consideration was expedited, debate taking place between January 25 and February 27, 1945. The reports accompanying the bills being debated both referred to the boycott provision, stating "These provisions of the Sherman Act remain in full force and effect."[6]

In the first Senate debate, on January 25, the boycott provision was broadened by a quickly accepted amendment

6. S. Rep. No. 20, 79th Cong., 1st Sess. (1945), accompanying S. 340; and H. Rep. No. 143, 79th Cong., 1st Sess. (1945).

from "Nothing contained in this section shall render the Sherman Act inapplicable to any agreement or act of boycott . . ." to "Nothing in this act . . ." 91 Cong. Rec. 479 (1945). The chief issue debated, reflecting Senator O'Mahoney's concern, was whether the act could be used to authorize attempts to monopolize. Senator Ferguson, a sponsor, gave the answer: "No. I will answer that by saying that if agreements in restraint of trade or to monopolize amounted either to a boycott and/or coercion and/or intimidation, they would be absolutely void . . . ." *Id.* at 480.

The bill was debated in the House on February 14. The language concerning "agreement" to boycott had been stricken in committee, but the deletion was challenged by Congressman Celler, who said his concern reflected the view of the Attorney General. Congressman Celler, in arguing for the restoration of "agreement" language, adverted to the danger of an oral blacklist being issued by large companies which "would frighten the wits out of all these small companies", and an agreement of "separation" barring a company whose agent wrote insurance for a blacklisted company from participation in "the self-constituted governing organizations". *Id.* at 1087. On Congressman McCormack's suggestion, language was accepted proscribing "any agreement to boycott, coerce, or intimidate". Much of the debate then focused on the nature of the moratorium of three years on the general application of the Sherman and Clayton Acts.

The bill went to conference. The House, on February 23, agreed to the conference report without debate. In the Senate, on February 26, Senator Pepper was concerned about states taking action during the moratorium period

which would defeat the purpose of the antitrust acts. Senator Ferguson replied that states could not, even during the moratorium, "interfere with the application of the Sherman Act to any agreement . . . or . . . act of boycotting". *Id.* at 1443. On the next day, Senator Pepper levelled his attack at the basic provision making the Sherman, Clayton, and Federal Trade Commission Acts permanently inapplicable to the extent that states had regulated the industry. His concern was that price fixing could continue with impunity. Senator O'Mahoney reassured him that private agreements enforcing certain rates would remain violations with the restoration of the "agreement" language taken out but restored by the House. He added:

> "Therefore any attempt by a small group of insurance companies to enter into an agreement by which they would penalize any person or any business which was attempting to do business in the insurance field in a way that was disapproved by them, would be absolutely prohibited by this provision." *Id.* at 1480.

Senator Pepper was not satisfied, believing that states could legitimize and therefore insulate rating bureaus. Senator Ferguson pointed out that "there are six things on which a State could not legislate. They are boycott, coercion, or intimidation, or agreements to boycott, coerce, or intimidate." *Id.* at 1481. He acknowledged that states would be permitted to authorize rating bureaus. Senator Pepper continued to gnaw at the issue, asking why the states should be given the right to "cloud" the Sherman and Clayton Acts. Again Senator O'Mahoney attempted reassurance by saying that there were three forms of regulation: state regulation permitted by the bill, federal regulation, which no one was urging, and private regulation by combinations "through private rules and regulations under which persons engaged in the insurance industry could be tried and convicted for the violation of private law". *Id.* at 1483. This latter type, he said, would be absolutely outlawed. Senator Pepper still felt that, with state-authorized rating bureaus being allowed by the bill, states were being given "carte blanche" to legitimize vices. *Id.* at 1484.

Senator O'Mahoney rejoined that "[t]he vice in the insurance industry . . . was not that there were rating bureaus, but that there was in the industry a system of private government which had been built up by a small group of insurance companies, which companies undertook by their agreements and understandings to invade the field of Congress to regulate commerce." *Id.* at 1485. After reading from the elaborate rules and regulations of a powerful association of insurance companies the Senator said, "The Insurance Executive Association undertook by regulation to coerce, intimidate, and boycott its own members and compel them to obey the rules and regulations the association itself prescribed." *Id.* at 1486.

Senator Barkley then asked if the boycott provision was sufficient to prevent combinations that do not involve boycott, coercion, or intimidation. Senator O'Mahoney replied,

> "[M]y judgment is that every effective combination or agreement to carry out a program against the public interest of which I have had any knowledge in this whole insurance study would be prohibited by the [boycott] section .... There are agree-

> ments and combinations in the public interests [sic] which can safely be permitted, but this agreement from which I have been reading is the sort of agreement which ought to be condemned . . . and which . . . would be completely outlawed." *Id.* at 1486.

The debate shortly ended and the conference report was accepted.

Assuming for the moment that we have license to go beyond the words of the statute, we cannot turn to the legislative history with our minds in equipoise. H. Hart and A. Sacks, *The Legal Process* 1264 (tent. ed. 1958). The plain meaning of the boycott provision, the strength of the nation's antitrust policies, and the substantial scope that an ordinary reading of the provision would leave to the McCarran-Ferguson Act—all these at the least create a presumption for the legislative history to overcome. Our question, then, is whether we can distill from this history the clear intent of Congress to limit "boycott, coercion, or intimidation" to acts or agreements affecting the relationships between insurance companies and their competitors and agents. The basis for appellees' argument lies in the remarks of Congressman Celler about the danger of blacklisting small companies and Senator O'Mahoney's remarks about the evil of private enforcement of private law by the companies. And it is true that at no point were any remarks directed to the possibility of boycotts, coercion, or intimidation aimed at consumers.

We would hesitate long before characterizing the Congressional intent as one narrowly restricting the boycott provision. We make two preliminary observations. The first is that *South-Eastern Underwriters,* which seems to

have been the ultimate source of the "boycott, coercion, or intimidation" language, apparently dealt in part with threats and boycotts directed at policyholders. 322 U.S. at 535. The second is that the insurance industry participated deeply in the drafting of this legislation; if the boycott provision were intended to cover less than what the Sherman Act would normally cover, one might suppose that the language would not have been left so bald and general.

Of more pertinence is the central role which the boycott provision played as the all purpose safety valve. It was amended twice, in each case to make it broader, first by making it effective across the entire Act and second by restoring the agreement language. Time after time the concerns of skeptics and opponents were met by reference to this provision. We cannot imagine that they would have been at all satisfied if they had understood that "boycott" was a code word confined to industry personnel. *See,* Levi *An Introduction to Legal Reasoning,* 15 U. Chi. L. Rev. 501, 522 (1948). The inescapable fact is that in this four-day debate the only specific references to evils were made on two occasions, once in the House and once in the Senate. Congressman Celler voted against the bill in the House and while Senator O'Mahoney was supporting the measure as an acceptable compromise and was on the committee of conference, he was not a sponsor. While the vice of insurance company self-government outside the law obviously lay in their minds as a major evil to be combatted by the legislation, there is no suggestion that the legislation was limited to that evil. Indeed Senator O'Mahoney referred to the Insurance Executives As-

sociation rules as "the sort of agreement" to be condemned. His summary answer to Senator Barkley that "every effective combination or agreement to carry out a program against the public interest" would be prohibited by the boycott section could not be more unrestricted.

We simply do not find in these debates or reports any evidence that would justify our reading the boycott provision in the special way urged by appellees. With all deference to the courts which have accepted the argument, we are reminded of the following advice of Mr. Justice Frankfurter:

> "Spurious use of legislative history must not swallow the legislation so as to give point to the quip that only when legislative history is doubtful do you go to the statute. While courts are no longer confined to the language, they are still confined by it. Violence must not be done to the words chosen by the legislature. Unless indeed no doubt can be left that the legislature has in fact used a private code, so that what appears to be violence to language is merely respect to special usage." Frankfurter, *Some Reflections on the Reading of Statutes,* 47 Colum. L. Rev. 527, 543-44 (1947).

We therefore reverse the lower court on this issue. The plaintiffs have charged the defendants with an unlawful boycott, and they are entitled to seek both injunctive relief and treble damages. *See Monarch Life Ins. Co.* v. *Loyal Protective Life Ins. Co.,* 326 F.2d 841 (2d Cir. 1963), cert. denied, 376 U.S. 952 (1964).[7]

7. We recognize that the dismissal could be affirmed if none of the plaintiffs have standing to sue. But the change in malpractice coverage has increased costs for the doctors. The alleged conspiracy

(footnote continued on next page)

The plaintiffs also object to the district court's decision to abstain on the plaintiffs' fraud claims, which were based on state law. In essence, plaintiffs pleaded that past and present insurance rates had been inflated by false statements to the public and the state insurance commissioner. Plaintiffs asked for restitution of all amounts paid in excess of a "fair and justifiable" malpractice insurance rate. Rhode Island courts have never ruled on the existence of a cause of action for recovery of excessive insurance premiums, but the district court noted that the state has provided elaborate administrative and judicial procedures for challenging existing rates. Rather than risk interfering with the state's regulatory scheme or misinterpreting state law, the district court abstained. Plaintiffs are apparently satisfied with the district court's decision to abstain with respect to insurance rates now in effect, for they do not appeal from that disposition. They do appeal from the court's abstention regarding past rates, which cannot be challenged administratively. The court's reluctance to take the case is understandable; recognizing a cause of action for the recovery of excessive past insurance premiums would profoundly affect the state's ratemaking machinery and policies. *See Burford* v. *Sun Oil Co.,* 319 U.S. 315 (1943); *Louisiana Power & Light Co.* v. *City of Thibodaux,* 360 U.S. 25 (1959). In cases like this, federal courts prefer to tread lightly, following trails already blazed by the

thus strikes at their "business or property", 15 U.S.C. §15, even if that phrase refers only to "commercial interests". *Hawaii* v. *Standard Oil Co.,* 405 U.S. 251, 264 (1972). And no one is more directly injured by a conspiracy among insurance sellers than those who buy the insurance. *See generally,* L. Sullivan, *Antitrust* §247 (1976). Because the doctors named as plaintiffs have standing, we find it unnecessary to decide whether the patients have standing or not.

state courts. Nonetheless, the court's jurisdiction over this claim was founded on diversity of citizenship. Abstaining in a diversity case often means completely relinquishing the case to the state courts; it thus defeats the purposes behind the grant of federal jurisdiction. A less drastic step might have served the purposes of the grant without unduly interfering in state regulatory matters. In Rhode Island, a novel and controlling question may be certified from the federal courts to the state courts. *See Lehman Bros.* v. *Schein,* 416 U.S. 386 (1974); R. I. Sup. Ct. Rule 6.

The district court did not certify this question. Two reasons for its choice are now advanced. First, the court's unappealed decision to abstain on the present rate question means that state courts and administrators will soon be wrestling with plaintiffs' claim, and it would not serve judicial economy for the federal court to begin work on a closely related claim. Second, even if a cause of action for recovering past premiums is proper, the federal court should abstain for fear of disrupting important state concerns. We doubt that either of these factors alone would permit abstention when balanced against the duty imposed on every federal court to decide cases within its jurisdiction. *See Meredith* v. *Winter Haven,* 320 U.S. 228 (1943). In combination, however, they persuade us that abstention was justifiable. *See Louisiana Power & Light Co.* v. *City of Thibodaux, supra,* 360 U.S. at 27 n. 2.

Appellants also object to the granting of summary judgment to two defendants, the Aetna and St. Paul insurance companies, on a count charging fraud in the sale of certain "consent to rate" policies. Plaintiffs offered

no evidence that any named physician-plaintiff ever bought such a policy from either Aetna or St. Paul, nor that any named patient-plaintiff was ever treated by a doctor holding such a policy. Appellants thus had at best only a tenuous right to bring this claim against these companies, *Haas* v. *Pittsburgh Nat'l Bank,* 526 F.2d 1083 (3d Cir. 1975), and we find no error in the district court's decision to adhere strictly to the traditional rules. *La Mar* v. *H & B Novelty & Loan Co.,* 489 F.2d 461, 469 (9th Cir. 1973). *See also O'Shea* v. *Littleton,* 414 U.S. 488, 494-95 (1974).

The district court disposed of the remaining charges of fraud in "consent to rate" policies by referring to Fed. R. Civ. P. 9(b). Rule 9(b) requires complaints charging fraud to state "with particularity" the circumstances constituting fraud. The judge found that the complaint did not meet the standards set by rule 9(b) and dismissed the count without prejudice. The judge was correct; the complaint could hardly be more vague. While the judge might have ordered a more definite statement, it was within his power to grant a dismissal without prejudice. If the plaintiffs can plead fraud with more particularity, they may file an amended complaint. 2A Moore's Federal Practice ¶9.03 p. 1934.

Affirmed in part; reversed and remanded in part.

Dissenting Opinion

CAMPBELL, *Circuit Judge* (dissenting in part). The court seems to me to be straining mightly to reinterpret the legal relationship ordinarily understood to have been established under the McCarran-Ferguson Act, perhaps because it has some doubts about the policies of that Act.

The McCarran-Ferguson Act declares that "the continued regulation and taxation by the several States of the business of insurance is in the public interest", 15 U.S.C. §1011, and "shall be subject to the laws of the several States which relate to the regulation or taxation of such business", §1012(a).[1] The Act goes on to say that no Act of Congress shall invalidate, impair or supersede state regulatory laws, §1012(b). Finally, it provides that the various antitrust statutes, including the Sherman Act, shall apply only to the extent a state does not exercise its right to regulate, §1012(b). The court concedes, as do the parties, that Rhode Island has exercised its right to regulate all material aspects of the business of insurance and that the actions complained of relative to withholding malpractice insurance were all part of such regulated business. Thus, under the clear implication of §1012, neither the Sherman Act nor the other antitrust laws apply except insofar as the §1013(b) exception permits. That exception provides, "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." Significantly this language does not track the broad "contract, combination . . . or conpiracy" language of the Sherman Act which Congress reasonably might have chosen had the intent been, as my brothers state, to encompass in the exception virtually all activities in violation of the Sherman Act involving more than an individual monopolist.

1. The Supreme Court has said that "[t]he relationship between insurer and insured, the type of policy which [can] be issued, its reliability, interpretation, and enforcement—these [are] the core of the 'business of insurance' " covered by the McCarran-Ferguson Act. *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969).

While the precise scope of the exception language may be less than crystal clear, given the statutory scheme, I have no difficulty understanding why two circuit courts and six district courts—every court except, now, ourselves—have held that the §1013(b) exemption is to be read narrowly as describing boycotts, coercion or intimidation directed against other companies and agents rather than, broadly, as also encompassing the gamut of company-policyholder relations. *See, e.g., Meicler* v. *Aetna Casualty & Surety Co.*, 372 F. Supp. 509, 513-14 (S.D. Tex. 1974), *aff'd*, 506 F.2d 732 (5th Cir. 1975). The legislative history indicates that the former problem was what worried Congress when it enacted the exception, and a narrow reading is more consistent with §1012 and with the purpose and structure of the act generally.[2] Indeed, to read §1013(b) expansively is to hold that what Congress gave with one hand it took with the other, since while my brothers' reading does not introdnce the entirety of federal antitrust law

2. I do not question that the boycott-coercion-intimidation language might in some other context be pushed to the limits which the court approves. But these words are hardly so focused as to permit only the broadest, most general meaning. A more limited interpretation, besides comporting with the statutory structure and the legislative history, squares with the Supreme Court's definition of a group boycott as "concerted refusals by traders to deal with other traders",

(footnote continued on next page)

into the business of insurance, it introduces a very major part thereof and does so with no clear explanation of why Congress should first take pains to eliminate the antitrust laws and then reintroduce by the back door most of the Sherman Act. Only if, like all other courts, we read §1013 (b) as dealing with a limited type of problem which troubled Congress does the exception fit sensibly into the statute as a whole.

The central thread running through the McCarran-Ferguson Act is that regulation of insurance rates and policies—both of them matters falling under the general heading of relations between companies and policy holders —is left to the states. The present litigation brought by physicians who believe that they have been deprived, unfairly, of insurance on terms that are economically favorable focuses precisely upon company-policyholder matters. My brothers are now putting the federal courts in the same arena as the State of Rhode Island, contrary, I believe, to the purposes of the McCarran-Ferguson Act. Doubtless the federal perspective is somewhat different but the poten-

---

Klor's Inc. v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1959). *See* L. Sullivan, Antitrust §90 at 257 (1976).

Furthermore, even reading the boycott exception to include the complained of behavior does not wholly solve the question of plaintiffs' standing. If St. Paul is attempting to corner the malpractice market, the more obvious harm is to those companies that are being closed out. It can be argued that the higher prices to doctors are only an indirect consequence and that the physicians have not suffered the sort of direct injury necessary to bring suit. *See Battle* v. *Liberty National Life Insurance Co.*, 493 F.2d 39, 49 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975) (plaintiff must show himself to be in sector of economy in which violation threatens to break down competitive conditions). This sort of problem suggests that the doctors' ostensible antitrust action is aimed less at protecting the free market system than at consumer protection goals left by Congress to state regulation. *See generally SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969).

tial for conflict between state regulation and federal antitrust policies is real and the decision has the effect of substantially undercutting §1012(b) of the Act.

This is, I think, a most unfortunate decision. It not only introduces a new category of federal antitrust suit which will be very difficult to manage at a time when federal courts are strained to the limit, but it could have unforeseeable effects upon state regulatory policies. Plaintiffs may see this case as another string to their bow in attempting to deal with the crushing malpractice burdens being imposed as the result not only, perhaps, of predatory insurance practices but of inflated claims and verdicts. We might sympathize with them without going this far. The State of Rhode Island has apparently now enacted regulatory legislation dealing with some or all of the problem—a means of redress which seems far more responsive to the problem than any likely to be achieved through reinterpreting the McCarran-Ferguson Act thirty years after enactment.

I shall not attempt to deal with the legislative history which my brothers make much of, beyond saying that, like most legislative history, it is capable of being argued both ways depending on which legislator one reads and to whose views one ascribes final authority. Certainly, in the expressed concerns of the legislators there is explicit support for the view which all other courts have adopted to date. More important to me, however, is the statutory scheme which suggests, in the positioning of the exception, and in the very fact that the exception is just that, that §1013(b) should be construed in a manner complementary to, rather than subversive of, the major premises of the Act. Under my brothers' reading, the tail now wags the dog.

I would affirm the district court which acted, I think, correctly and in accordance with all existing law.

Judgment of the United States Court of Appeals for the First Circuit

UNITED STATES COURT OF APPEALS

FOR THE FIRST CIRCUIT

No. 76-1226

DAVID M. BARRY, M.D., *et al.*,
Plaintiffs, Appellants,

v.

ST. PAUL FIRE & MARINE INSURANCE COMPANY, *et al.*,
Defendants, Appellees.

JUDGMENT

Entered May 16, 1977

This cause came on to be heard on appeal from the United States District Court for the District of Rhode Island, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the district court is affirmed in part; and the said judgment is vacated in part and remanded in part for further proceedings consistent with the opinion of the court filed this day.

Appellants are to recover one half costs.

By the Court:

/s/ Dana H. Gallup
Clerk

[cc: Messrs. Decof, Rosdeitcher and Comegys.]

FEDERAL STATUTES

Title 15, Commerce and Trade

The Sherman Act

Section 1, 15 U.S.C. §1 (Supp. V, 1975):

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy declared by sections 1 to 7 of this title to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Section 2, 15 U.S.C. §2 (Supp. V, 1975):

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

The Clayton Act

Section 4, 15 U.S.C. §15 (1970):

Any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States

in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee.

Section 16, 15 U.S.C.A. §26, 90 Stat. 1396 (1976):

Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties, against threatened loss or damage by a violation of the antitrust laws, including sections 13, 14, 18 and 19 of this title, when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage is granted by courts of equity, under the rules governing such proceedings, and upon the execution of proper bond against damages for an injunction improvidently granted and a showing that the danger of irreparable loss or damage is immediate, a preliminary injunction may issue: *Provided,* That nothing herein contained shall be construed to entitle any person, firm, corporation, or association, except the United States, to bring suit in equity for injunctive relief against any common carrier subject to the provisions of the Act to regulate commerce, approved February fourth, eighteen hundred and eighty-seven, in respect of any matter subject to the regulation, supervision, or other jurisdiction of the Interstate Commerce Commission. In any action under this section in which the plaintiff substantially prevails, the court shall award the cost of suit, including a reasonable attorney's fee, to such plaintiff.

The McCarran-Ferguson Act

Section 1, 15 U.S.C. §1011 (1970):

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States. Mar. 9, 1945, c. 20, §1, 59 Stat. 33.

Section 2, 15 U.S.C. §1012 (1970):

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Section 3, 15 U.S.C. §1013 (1970):

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade

Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Title 28, Judiciary and Judicial Procedure

28 U.S.C. §1254 (1970):

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

(2) By appeal by a party relying on a State statute held by a court of appeals to be invalid as repugnant to the Constitution, treaties or laws of the United States, but such appeal shall preclude review by writ of certiorari at the instance of such appellant, and the review on appeal shall be restricted to the Federal questions presented;

(3) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

28 U.S.C.A. §1331, 90 Stat. 2721 (1976):

(a) The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution, laws, or treaties of the United States except that no such sum or value shall be required in any such action brought against the United States, any agency thereof, or any officer or employee thereof in his official capacity.

(b) Except when express provision therefor is otherwise made in a statute of the United States, where the plaintiff is finally adjudged to be entitled to recover less than the sum or value of $10,000, computed without regard to any setoff or counterclaim to which the defendant may be adjudged to be entitled, and exclusive of interests and costs, the district court may deny costs to the plaintiff and, in addition, may impose costs on the plaintiff.

28 U.S.C. §1337 (1970):

The district courts shall have original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce or protecting trade and commerce against restraints and monopolies.

Federal Rules of Civil Procedure

Rule 12. Defenses and Objections—When and How Presented—By Pleading or Motion—Motion for Judgment on the Pleadings

(a) When Presented. A defendant shall serve his answer within 20 days after the service of the summons and complaint upon him, except when service is made under Rule 4(e) and a different time is prescribed in the order of court under the statute of the United States or in the statute or rule of court of the state. A party served with a pleading stating a cross-claim against him shall serve an answer thereto within 20 days after the service upon him. The plaintiff shall serve his reply to a counterclaim in the answer within 20 days after service of the answer, or, if a reply is ordered by the court, within 20 days after service of the order, unless the order otherwise directs. The United States or an officer or agency thereof shall serve an answer to the complaint or to a cross-claim, or a reply to a counterclaim, within 60 days after the service upon the United States attorney of the pleading in which the claim is asserted. The service of a motion permitted under this rule alters these periods of time as follows, unless a different time is fixed by order of the court: (1) if the court denies the motion or postpones its disposition until the trial on the merits, the responsive pleading shall be served within 10 days after notice of the court's action; (2) if the court grants a motion for a more definite statement the responsive pleading shall be served within 10 days after the service of the more definite statement.

(b) How Presented. Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: (1) lack of jurisdiction over the subject matter, (2) lack of jurisdiction over the person, (3) improper venue, (4) insufficiency of process, (5) insufficiency of service of process, (6) failure to state a claim upon which relief can be granted, (7) failure to join a party under Rule 19. A motion making any of these defenses shall be made before pleading if a further pleading is permitted. No defense or objection is waived by being joined with one or more other defenses or objections in a responsive pleading or motion. If a pleading sets forth a claim for relief to which the adverse party is not required to serve a responsive pleading, he may assert at the trial any defense in law or fact to that claim for relief. If, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

(c) Motion for Judgment on the Pleadings. After the pleadings are closed but within such time as not to delay the trial, any party may move for judgment on the pleadings. If, on a motion for judgment on the pleadings, matters outside the pleadings are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

(d) Preliminary Hearings. The defenses specifically enumerated (1)-(7) in subdivision (b) of this rule, whether made in a pleading or by motion, and the motion for judgment mentioned in subdivision (c) of this rule shall be heard and determined before trial on application of any party, unless the court orders that the hearing and determination thereof be deferred until the trial.

(e) Motion for More Definite Statement. If a pleading to which a responsive pleading is permitted is so vague or ambiguous that a party cannot reasonably be required to frame a responsive pleading, he may move for a more definite statement before interposing his responsive pleading. The motion shall point out the defects complained of and the details desired. If the motion is granted and the order of the court is not obeyed within 10 days after notice of the order or within such other time as the court may fix, the court may strike the pleading to which the motion was directed or make such order as it deems just.

(f) Motion to Strike. Upon motion made by a party before responding to a pleading or, if no responsive pleading is permitted by these rules, upon motion made by a party within 20 days after the service of the pleading upon him or upon the court's own initiative at any time, the court may order stricken from any pleading any insufficient defense or any redundant, immaterial, impertinent, or scandalous matter.

(g) Consolidation of Defenses in Motion. A party who makes a motion under this rule may join with it any other motions herein provided for and then available to him. If a party makes a motion under this rule but omits therefrom any defense or objection then available to him which this rule permits to be raised by motion, he shall not thereafter make a motion based on the defense or objection so omitted, except a motion as provided in subdivision (h) (2) hereof on any of the grounds there stated.

(h) Waiver or Preservation of Certain Defenses.

(1) A defense of lack of jurisdiction over the person, improper venue, insufficiency of process, or insufficiency of service of process is waived (A) if omitted from a motion in the circumstances described in subdivision (g), or (B)

if it is neither made by motion under this rule nor included in a responsive pleading or an amendment thereof permitted by Rule 15(a) to be made as a matter of course.

(2) A defense of failure to state a claim upon which relief can be granted, a defense of failure to join a party indispensable under Rule 19, and an objection of failure to state a legal defense to a claim may be made in any pleading permitted or ordered under Rule 7(a), or by motion for judgment on the pleadings, or at the trial on the merits.

(3) Whenever it appears by suggestion of the parties or otherwise that the court lacks jurisdiction of the subject matter, the court shall dismiss the action. As amended Jan. 21, 1963, eff. July 1, 1963; Feb. 28, 1966, eff. July 1, 1966.

STATE STATUTES AND REGULATIONS

Rhode Island General Laws

Title 27—Insurance

CHAPTER 9

Casualty Insurance Rating

27-9-4. Considerations in making of rates.—All rates shall be made in accordance with the following provisions:

1. Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both country-wide and those specially applicable to this state, and to all other relevant factors within and outside this state;

2. The systems of expense provisions included in the rates for use by any insurer or group insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

3. Risks may be grouped by classifications for the establishment of rates and minimum premiums;

4. Rates shall not be excessive, inadequate or unfairly discriminatory.

27-9-7. Filing of rate plans and systems.—Every insurer shall file with the commissioner every manual of

classification, rules and rates, every rating plan, rating system and every modification of any of the foregoing which it proposes to use; provided, however, that classification rates may be modified without additional filing to produce rates for individual risks which are lower than those filed and which evaluate variations in physical or moral hazards, individual risk experience or expense provisions, and which are not inadequate or unfairly discriminatory. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports such filing, and the commissioner does not have sufficient information to determine whether such filing meets the requirements of the chapter, he may require such insurer to furnish the information upon which it supports such filing. The information furnished in support of a filing may include (1) the experience or judgment of the insurer or rating organization making the filing, (2) its interpretation of any statistical data it relies upon, (3) the experience of other insurers or rating organizations, or (4) any other relevant factors. A filing and any supporting information shall be open to public inspection.

27-9-15. Review of rates not covered by filings.—Within ten (10) days after any insurer shall have made or issued a contract or policy at a rate or premium other than is provided for by any filing made with the commissioner by or in its behalf, such insurer shall notify the commissioner in writing of such action in such form as the commissioner may require. The commissioner shall review such notice as soon as reasonably possible after it has been received by him, in order to determine whether such contract or policy has been written at a rate or premium which meets the requirements of this chapter. When such notice is not ac-

companied by the information upon which the insurer supports such rate or premium, and the commissioner does not have sufficient information to determine whether such rate or premium meets the requirements of the chapter, he shall require such insurer to furnish, within ten (10) days after receipt of notice of such requirement, the information upon which it supports such rate or premium. Unless within thirty (30) days after receipt of such notice or such supporting information, the commissioner shall issue an order following a hearing, as provided in §27-9-18, the rate or premium charged for such contract or policy shall be deemed to meet the requirements of this chapter; provided, however, that all contracts and policies issued under the provisions of this section shall state that the rate or premium charged therefor has not been reviewed by the commissioner and that it is subject to disapproval or modification as of the effective date of said contracts or policies.

27-9-16. Disapproval of filing within waiting period.—If within the waiting period or any extension thereof as provided in §27-9-10, the commissioner finds that a filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing specifying therein in what respects he finds such filing fails to meet the requirements of this chapter and stating that such filing shall not become effective.

27-9-18. Disapproval of filing after review period—Removal of discrimination.—If at any time subsequent to the applicable review period provided for in §27-9-16 or §27-9-17, the commissioner finds that a rate or filing does not meet the requirements of this chapter, he shall, after a hearing held upon not less than ten (10) days' written notice, specifying the matters to be considered at such hear-

ing, to every insurer and rating organization which used such rate or made such filing, issue an order specifying in what respects he finds that such rate or such filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, such rate shall no longer be used or such filing shall be deemed no longer effective. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order. If, however, the commissioner finds that an unfair discrimination exists in the application of a rate or filing to an individual risk he may, after a hearing held on like notice to the insurer affected and to any rating organization which made such filing, issue an order that such discrimination be removed. Copies of any order issued hereunder shall be sent to every such insurer and rating organization.

27-9-19. Hearings on application by persons aggrieved by filing—Order terminating filing—Removal of discrimination.—Any person or organization aggrieved with respect to any rate or filing which is in effect may make written application to the commissioner for a hearing thereon, provided, however, that the insurer or rating organization that uses such rate or made the filing shall not be authorized to proceed under this section. Such application shall specify the grounds to be relied upon by the applicant. If the commissioner shall find that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall, within thirty (30) days after receipt of such application, hold a hearing upon not less than ten (10) days' written notice to the applicant and to every insurer and rating organization which uses such rate or made such filing; provided, however, if a public hearing had been held concerning such rate or filing before it became effective, no hearing shall be held pur-

suant to this section unless the commissioner shall find that there has been a substantial change of circumstances since such hearing.

If, after such hearing, the commissioner finds that the rate or filing does not meet the requirements of this chapter, he shall issue an order specifying in what respects he finds that such rate or filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, such rate shall no longer be used or such filing shall be deemed no longer effective. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order. If, however, the commissioner finds that an unfair discrimination exists in the application of a rate or filing to an individual risk he may, after a hearing held on like notice to the insurer affected and to any rating organization which made such filing, issue an order that such discrimination be removed. Copies of any order issued hereunder shall be sent to every such insurer and rating organization.

27-9-42. False or misleading information.—No person or organization shall wilfully withhold information from or knowingly give false or misleading information to the commissioner, to any statistical agency designated by the commissioner, to any rating organization, or to any insurer, which will affect the rates or premiums chargeable under this chapter. A violation of this section shall subject the one guilty of such violation to the penalties provided in §§27-9-45 and 27-9-46.

27-9-45. Penalty for violations.—Any person or organization wilfully violating any provision of this chapter shall, upon conviction thereof, be fined not less than one hundred dollars ($100) and not more than five hundred dollars ($500) for each such violation. Such penalty may be in addition to any other penalty provided by law.

27-9-46. Suspension or revocation of licenses.—The commissioner may suspend the license of any rating organization or insurer which fails to comply with an order of the commissioner within the time limited by such order, or any extension thereof which the commissioner may grant. The commissioner shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or, if an appeal has been taken, until such order has been affirmed.

The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the period fixed by him, unless he modifies or rescinds such suspension, or until the order upon which such suspension is based is modified, rescinded or reversed.

No license shall be suspended or revoked except upon a written order of the commissioner, stating his findings, made after a hearing held upon not less than ten (10) days' written notice to such person or organization specifying the alleged violation.

CHAPTER 29

Unfair Competition and Practices

27-29-1. Declaration of purpose.—The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 (public law 15, 79th congress) by defining—or providing for the determination of—all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

27-29-2. Definitions.—When used in this chapter:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters.

(b) "Commissioner" shall mean the insurance commissioner of this state.

27-29-3. Unfair methods of competition or unfair and deceptive acts or practices prohibited.—No person shall engage in this state in any trade practice which is defined in this chapter as—or determined pursuant to this chapter to be—an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

27-29-4. Unfair methods of competition and unfair or deceptive acts or practices defined.—The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

1. *Misrepresentations and false advertising of policy contracts.* Making, issuing, circulating or causing to be

made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit or surrender his insurance.

2. *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

3. *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article of literature which is false or maliciously critical of or derogatory to the financial condition of an

insurer, and which is calculated to injure any person engaged in the business of insurance.

4. *Boycott, coercion and intimidation.* Entering into any agreement to commit—or by any concerted action committing—any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

5. *False financial statements.* Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person or placed before the public any false statement of financial condition of an insurer with intent to deceive.

Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or with like intent wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

6. *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities of any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

7. *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same

class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

8. *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing or giving or offering to pay, allow or give directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling or purchasing or offering to give, sell or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in clause "7" or paragraph "(a)" of clause "8" of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

9. *Free choice of agent or insurer.* When any person, firm or corporation engaged in the business of lending money on the security of real or personal property, or in the business of negotiating, purchasing, selling or holding loans on the security of such property, or in the business of building, selling, or financing the sale or purchase of such property, or any trustee, director, officer, agent, or other employee of any such person, firm or corporation, requires that property insurance be procured for such property, the borrower, debtor or purchaser shall have free choice of agent and insurer through or by which such insurance is to be placed or written, subject only to the right of the builder, creditor, lender or seller (1) to require evidence, to be produced at a reasonable time prior to commencement or renewal [of] risk, that such insurance providing reasonable coverage has been obtained in an amount equal to the amount required by said builder, creditor, lender or seller;

(2) to require insurance in an insurer authorized to do business and having a licensed resident agent in this state; and (3) to refuse to accept insurance in a particular insurer on reasonable grounds related to solvency.

When any contractor or subcontractor is required to procure a surety bond or policy of insurance with respect to any building or construction contract which is about to be, or which has been bid or entered into, the contractor or subcontractor shall have free choice of agent and insurer through or by which such surety bond or insurance is to be written, provided, however, that the owner or contractor shall have the right (1) to require evidence, to be produced at a reasonable time prior to commencement or renewal [of] risk, that such insurance providing reasonable coverage has been obtained in an amount equal to the amount required by said builder, creditor, lender or seller; (2) to require insurance in an insurer authorized to do business and having a licensed resident agent in this state; and (3) to refuse to accept insurance in a particular insurer on reasonable grounds related to solvency, and, provided further, however, that the owner or contractor shall have the right to approve the form, sufficiency or manner of execution of the surety bond or policy or insurance furnished by the insurance company or agent selected by the contractor or subcontractor.

10. *Notice of free choice of agent or insurer.* Every debtor, borrower or purchaser of property with respect to which insurance of any kind on the property is required in connection with a debt or loan secured by such property or in connection with the sale of such property, shall be informed in writing by the builder, creditor, lender or seller, of his right of free choice in the selection of the agent and insurer through or by which such insurance is to be placed. There shall be no interference either directly or indirectly with such borrower's, debtor's or purchaser's free choice of an agent and of an insurer which complies

with the foregoing requirements, and the builder, creditor, lender, seller, owner or contractor shall not refuse the policy so tendered by the borrower, debtor, purchaser, contractor or subcontractor. Upon notice of any refusal of such tendered policy, the insurance commissioner shall order the builder, creditor, lender, seller, owner or contractor to accept the tendered policy, if he determines that such refusal is not in accordance with the foregoing requirements. Failure to comply with such an order of the insurance commissioner shall be deemed a violation of this section.

11. *Using insurance information to detriment of another.* Whenever the instrument requires that the purchaser, mortgagor or borrower furnish insurance of any kind on real property being conveyed or is collateral security to a loan, the mortgagee, vendor or lender shall refrain from disclosing or using any and all such insurance information to his or its own advantage and to the detriment of either the borrower, purchaser, mortgagor, insurance company or agency complying with the requirements relating to insurance.

27-29-4.1. Cancellation of insurance prohibited.—No insurance company authorized to do business in this state shall cancel or refuse to issue any type of insurance coverage for an owner occupied dwelling or personal property of every nature and description solely because of the area in which such property is situated.

27-29-4.2. Penalty.—For each violation of §27-29-4.1, the offening insurance company shall be fined a sum of five hundred dollars ($500) by the department of business regulation.

27-29-5. Hearings—Witnesses—Appearances—Production of books—Service of process.—(a) Whenever the insurance commissioner shall have reason to believe that any person engaged in the business of insurance in this state has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in §27-29-4, and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon requiring such person to appear in person at a time and place fixed in the notice which shall not be less than ten (10) days after the date of the service thereof, and notifying him of his right to be represented by counsel at such hearing.

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard in person and by counsel, and to show cause why an order should not be made by the insurance commissioner requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown the insurance commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

(c) The insurance commissioner upon such hearing shall cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing, and shall, upon request, furnish a copy thereof to the person charged upon being reimbursed for the reasonable costs thereof. The insurance commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence or other documents which are relevant to

the inquiry. In case of a refusal of any person to comply with any subpoena issued hereunder or of any witness to testify with respect to any matter concerning which he may be lawfully interrogated the superior court of Providence county, on application of the insurance commissioner, may issue an order requiring such person or witness to comply with such subpoena and/or to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof; provided, however, that the person charged shall not be required to testify or produce books, papers, records, correspondence or other documents, tending to incriminate him, and his refusal to testify or produce books, papers, records, correspondence or other documents in such case shall not constitute contempt nor be the basis for an application by the insurance commissioner for an order requiring the person charged to testify or produce books, papers, records, correspondence or other documents; and provided further that a refusal of such person charged to testify or produce books, papers, records, correspondence or other documents shall be sufficient ground for the suspension or revocation of any license such person has under the insurance laws of this state in the discretion of the insurance commissioner.

(d) Statements of charges, notices, orders and other processes of the insurance commissioner under this chapter may be served by anyone duly authorized by the insurance commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by such statement, notice, order or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order or other process setting forth the manner of such service shall be proof of the same, and the return postcard receipt for such statement, notice, order or other process registered

and mailed as aforesaid shall be proof of the service of the same.

27-29-6. Cease and desist orders and modifications thereof.—(a) If after such hearing the insurance commissioner shall determine that the method of competition or the act or practice in question is defined in §27-29-4 and that the person complained of has engaged in such method of competition, act or practice in violation of this chapter, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice.

(b) Until the expiration of the time allowed under §27-29-7(a) for filing a petition for review if no such petition has been duly filed within such time, the insurance commissioner may at any time upon such notice and in such manner as he shall deem proper, modify or set aside in whole or in part any order issued by him under this section.

(c) After the expiration of the time allowed for filing such a petition for review if no such petition has been duly filed within such time, the insurance commissioner may at any time, after notice and opportunity for hearing, re-open and alter, modify or set aside, in whole or in part, any order issued by him under this section whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest shall so require.

27-29-7. Judicial review of cease and desist orders.—(a) Any person required by an order of the insurance commissioner under §27-29-6 to cease and desist from engaging in any unfair method of competition or any unfair or deceptive act or practice as defined may obtain a review of such order by filing in the superior court of Providence

county within twenty (20) days from the date of service of such order a written petition praying that the order of the insurance commissioner be set aside. A copy of such petition shall be forthwith served upon the insurance commissioner, and thereupon the insurance commissioner forthwith shall certify and file in such court his transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the insurance commissioner. Upon such filing of the petition and transcript the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the insurance commissioner, and shall have power to make and enter upon the pleadings, evidence, and proceedings set forth in such transcript a decree modifying, affirming or reversing the order of the insurance commissioner, in whole or in part. The findings of the insurance commissioner as to the facts, if supported by the weight of the evidence, shall be conclusive.

(b) To the extent that the order of the insurance commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the insurance commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the insurance commissioner, the court may order such additional evidence to be taken before the insurance commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The insurance commissioner may modify his findings of fact, or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings which if supported by competent

evidence shall be conclusive, and his recommendation, if any, for the modification or setting aside of his original order, with the return of such additional evidence.

(c) A cease and desist order issued by the insurance commissioner under §27-29-6 shall become final—

1. Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the insurance commissioner may thereafter modify or set aside his order to the extent provided in §27-29-6(b); or

2. Upon the final decision of the court if the court directs that the order of the insurance commissioner be affirmed or the petition for review dismissed.

(d) No order of the insurance commissioner under this chapter or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

27-29-8. Procedure as to unfair methods of competition and unfair or deceptive acts or practices which are not defined.—(a) Whenever the insurance commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in §27-29-4, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charge in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice. Each such hearing shall be conducted in the same manner as the hearing provided for in §27-29-5. The insurance commissioner shall

after such hearings make a report in writing in which he shall state his findings as to the facts, and he shall serve a copy thereof upon such person.

(b) If such report charges a violation of this chapter and if such method of competition, act or practice has not been discontinued, the insurance commissioner may—through the attorney general of this state—at any time after ten (10) days after the service of such report, cause a petition to be filed in the superior court of this state for the counties of Providence and Bristol to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(c) A transcript of the proceedings before the insurance commissioner, including all evidence taken and the report and findings, shall be filed with such petition. If either party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and there were reasonable grounds for the failure to adduce such evidence in the proceedings before the insurance commissioner, the court may order such additional evidence to be taken before the insurance commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The insurance commissioner may modify his findings of fact or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings with the return of such additional evidence.

(d) If the court finds that the method of competition complained of is unfair or that the act or practice com-

plained of is unfair or deceptive, that the proceeding by the insurance commissioner with respect thereto is to the interest of the public and that the findings of the insurance commissioner are supported by the weight of the evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

27-29-9. Penalty.—Any person who violates a cease and desist order of the insurance commissioner under §27-29-6 after it has become final, and while such order is in effect, shall—upon proof thereof to the satisfaction of the court—forfeit and pay to the state of Rhode Island a sum not to exceed fifty dollars ($50), which may be recovered in a civil action except that, if such violation is found to be wilful, the amount of such penalty shall be a sum not to exceed five hundred dollars ($500).

27-29-10. Provisions of act additional to existing law.—The powers vested in the insurance commissioner by this chapter shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

27-29-11. Separability provision.—If any provision of this chapter, or the application of such provision to any person or circumstances shall be held invalid, the remainder of the chapter, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Title 42—State Affairs and Government

CHAPTER 14.1

DEPARTMENT OF
BUSINESS REGULATION—REGULATORY AUTHORITY
MEDICAL MALPRACTICE INSURANCE
(Enactment of January 12, 1976)
STATE OF RHODE ISLAND, &C.
In General Assembly

JANUARY SESSION, A.D. 1976

AN ACT

RELATING TO THE REGULATORY AUTHORITY OF THE DEPARTMENT BUSINESS REGULATION

It is enacted by the General Assembly as follows:

SECTION 1. Title 42 of the general laws, entitled "State Affairs and Government", is hereby amended by adding thereto the following chapter:

CHAPTER 14.1

Department of Business Regulation-Regulatory Authority-Medical Malpractice Insurance

42-14.1-1. Upon a finding by the Director of Business Regulation that there exists a lack of competitive, stable market for medical malpractice insurance in the State of Rhode Island and that as a consequence thereof, there is peril to the public health safety and welfare of the people of the State of Rhode Island, the Director is authorized to promulgate a regulation addressed to the solution of such problem which may encompass among others, the following provisions:

Medical Malpractice Insurance

A. Creation of a joint underwriting association consisting of all insurers authorized to write, within this state on a direct basis, personal injury liability insurance as defined in Title 27-9-2 of the General Laws of Rhode Island, including insurers covering such perils in multiple peril package policies. Every such insurer shall be a member of the Association and shall remain a member as a condition of its authority to continue to transact such kinds of insurance in this state.

B. To effectuate the purpose of the Association which is to provide on a temporary basis, a market for medical malpractice insurance on a self-supporting basis, the Association shall be the exclusive agency through which medical malpractice insurance may be written in this State on a primary basis for physicians. The Association shall be authorized to issue policies of medical malpractice insurance to hospitals and other health care providers, but need not be the exclusive agency through which such insurance may be written on a primary basis in this state.

C. Policies issued by the Association shall be subject to a group retrospective rating plan to be approved by the Director of Business Regulation and shall be calculated to be self-supporting.

D. The creation and administration of a stabilization reserve fund and initial policyholder contribution to such fund. The purpose of the Fund shall be the discharge when due of any retrospective premium charges payable by policyholders of the Association under the group retrospective rating plan authorized by regulation. Any monies remaining in the Fund after all such retrospective premium charges have been paid shall be returned to policyholders.

E. Upon certification by the Association to the Director that the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the Association, the Director shall authorize members of the Association to commence recoupment by one of the following procedures:

a] applying a surcharge to be determined by the Association at a rate not to exceed one [1] percent of the annual premiums on future policies affording those kinds of insurance which form the basis for their participation in the Association, under procedures established by the Association or

b] deducting their share of the deficit from past or future taxes due the State of Rhode Island.

F. Organization of a plan of operation, use of policies written on a "claim made" or "occurrence basis", participation of members of the Association and all other powers necessary to effectuate the purposes of such regulation.

Section 2. This act validates Emergency Regulation XXI promulgated by the Department of Business Regulation on June 16, 1975, and further extends said regulation for an additional period of ninety [90] days, notwithstanding any other provision of law, or until such time as a permanent regulation is duly promulgated, whichever occurs first.

Section 3. This act shall take effect upon its passage.

CHAPTER 14.1

DEPARTMENT OF
BUSINESS REGULATION—REGULATORY AUTHORITY
MEDICAL MALPRACTICE INSURANCE
(As Amended May 14, 1976)

STATE OF RHODE ISLAND, &C.
In General Assembly

JANUARY SESSION, A.D. 1976

AN ACT

RELATING TO THE
REGULATORY AUTHORITY OF THE
DEPARTMENT OF BUSINESS REGULATION

*It is enacted by the General Assembly as follows:**

Section 1. Title 42 of the general laws entitled "State Affairs and Government", as amended by 76-H-7017 which became law on January 12, 1976, is hereby further amended as follows:

Chapter 14.1

Department of Business Regulation
Regulatory Authority
Medical Malpractice Insurance

42-14.1-1. • • •

A. • • •

B. To effectuate the purpose of the association which is to provide **on a temporary basis**, a market for medical malpractice insurance on a self-supporting

* Matter in Boldface deleted by the General Assembly; matter in italics added by the General Assembly.

basis, the association shall be **the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis for physicans. The association shall be** authorized to issue policies of medical malpractice *and incidental liability* insurance to *phycians,* hospitals and other health care providers, but need not be the exclusive agency through which such insurance may be written on a primary basis in **this state.**

C. • • •
D. • • •
E. • • •
F. • • •

G. *Any joint underwriting association created pursuant to the authority granted in this chapter shall be exempt from taxation on gross premiums and stabilization reserve funds received for medical malpractice insurance as provided for in §44-17-1. This provision shall be applied retroactively to June 16, 1975, but in no way shall allow an exemption from taxation for premiums received other than for medical malpractice insurance.*

Section 2. • • •

Section 3. This act shall take effect upon its passage.

CHAPTER 35

Administrative Procedures

42-35-15. Judicial review of contested cases.—(a) Any person who has exhausted all administrative remedies available to him within the agency, and who is aggrieved by a final decision in a contested case is entitled to judicial review under this chapter. This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by law. Any preliminary, procedural, or intermediate agency act or ruling is immediately reviewable in any case in which review of the final agency decision would not provide an adequate remedy.

(b) Proceedings for review are instituted by filing a complaint in the superior court of Providence county, or where expressly provided by the general laws in the sixth division of the district court, within thirty (30) days after mailing notice of the final decision of the agency or, if a rehearing is requested, within thirty (30) days after the decision thereon, provided, however, that any person who is aggrieved by a final decision concerning the assessment or determination of any tax, interest or penalty made by the tax administrator must pay the amount of such tax, interest or penalty to said administrator as a prerequisite to the filing of such complaint. Copies of the complaint shall be served upon the agency and all other parties of record in the manner prescribed by applicable procedural rules.

(c) The filing of the complaint does not itself stay enforcement of the agency decision. The agency may grant, or the reviewing court may order, a stay upon appropriate terms.

(d) Within thirty (30) days after the service of the complaint, or within further time allowed by the court, the

agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review. By stipulation of all parties to the review proceedings, the record may be shortened. Any party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record.

(e) If, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the court that the additional evidence is material and that there were good reasons for failure to present it in the proceeding before the agency, the court may order that the additional evidence be taken before the agency upon conditions determined by the court. The agency may modify its findings and decision by reason of the additional evidence and shall file that evidence and any modifications, new findings or decisions with the reviewing court.

(f) The review shall be conducted by the court without a jury and shall be confined to the record. In cases of alleged irregularities in procedure before the agency, not shown in the record, proof thereon may be taken in the court. The court, upon request, shall hear oral argument and receive written briefs.

(g) The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings, or it may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the adminitsrative findings, inferences, conclusions, or decisions are:

(1) in violation of constitutional or statutory provisions;

(2) in excess of the statutory authority of the agency;

(3) made upon unlawful procedure;

(4) affected by other error of law;

(5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Title 39—Public Utilities and Carriers

39-3-13. Emergency suspension of rate schedules.—The said division shall have power, when deemed by it necessary to prevent injury to the business or interest of the people or any public utility of this state in case of any emergency to be judged of by the said division, to permit any public utility to temporarily alter, amend or suspend any existing rates, schedules and order relating to or affecting any public utility or part of any public utility in this state.

STATE OF RHODE ISLAND

DEPARTMENT OF BUSINESS REGULATION

INSURANCE DIVISION

[SEAL]

Emergency Regulation

XXI

Medical Malpractice Joint Underwriting
Association of Rhode Island

Effective June 16, 1975

Philip W. Noel, Governor

Robert E. Liguori, Director, Dept. of Business Regulation

Peter F. Mullaney, Insurance Commissioner

Emergency Regulation XXI

REGULATION XXI

MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION OF RHODE ISLAND

Section 1. Statement of findings and purpose.

Section 2. Definitions.

Section 3. Temporary joint underwriting association.

Section 4. Plan of operation.

Section 5. Policy forms and rates.

Section 6. Stabilization reserve fund.

Section 7. Procedures.

Section 8. Participation.

Section 9. Directors.

Section 10. Appeals and judicial review.

Section 11. Annual Statements.

Section 12. Examinations.

Section 13. Privileged communications.

Section 14. Public officers or employees.

Section 15. Effective date and severability clause.

Emergency Regulation XXI

SECTION 1. STATEMENT OF FINDINGS AND PURPOSE.

The Director of Business Regulation hereby finds that:

1. There presently exists a lack of competitive stable market for medical malpractice insurance in the State of Rhode Island.

2. As a result, physicians and surgeons have manifested an intent to withhold all but emergency services commencing July 1, 1975.

3. There is a resulting potential endangerment to the continued financial integrity and existence of hospitals and other health care institutions in Rhode Island.

4. There is a peril to the entire health care delivery system in Rhode Island.

5. There is an imminent peril to the public health safety and welfare of the people of the State of Rhode Island.

6. There is an immediate need to provide a stable facility for medical malpractice insurance prior to July 1, 1975.

Therefore, in accordance with Title 42, Chapter 35, Section 3, of the General Laws of Rhode Island, there is hereby promulgated and adopted the following emergency regulations which shall be known as the Medical Malpractice Joint Underwriting Association of Rhode Island.

The basic purpose of this regulation is to provide for a temporary market to make the necessary medical malpractice insurance available for a period not to exceed two years. This will allow time for the Governor's commission on Medical Malpractice Reform to make its report, consideration of its recommendations and the enactment of any appropriate and necessary legislation.

Emergency Regulation XXI

SECTION 2. DEFINITIONS.

As used in this regulation:

1. "Association" means the temporary non exclusive joint underwriting association established pursuant to the provisions of this regulation.

2. "Medical Malpractice Insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, hospital or other licensed health care provider as defined in the General Laws of Rhode Island.

3. "Net direct premiums" means gross direct premiums written on personal injury liability insurance (as defined in Title 27-9-2 of the General Laws of Rhode Island) including the liability component of multiple peril package policies as computed by the Director of Business Regulation (hereinafter referred to as "Director"), less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

SECTION 3. TEMPORARY EXCLUSIVE JOINT UNDERWRITING ASSOCIATION.

1. A temporary exclusive joint underwriting association is hereby created, consisting of all insurers authorized to write, within this state on a direct basis, personal injury liability insurance as defined in Title 27-9-2 of the General Laws of Rhode Island, including insurers covering such

perils in multiple peril package policies. Every such insurer shall be a member of the Association and shall remain a member as a condition of its authority to continue to transact such kinds of insurance in this state. An organizational meeting of the members of the Association shall be held at the Department of Business Regulation, 169 Weybosset Street, Providence, Rhode Island, at 10 a.m., on June 16, 1975.

2. The purpose of the Association shall be to provide, on a temporary basis, but in no event to exceed 12:01 a.m., July 1, 1977, a market for medical malpractice insurance on a self-supporting basis without subsidy from its members.

3. The Association shall commence underwriting operations for physicians, hospitals and other licensed health care providers within 5 days of approval by the Director of the plan of operation as set forth in Section 4 as hereinafter provided. The Association shall be the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis for physicians. The Association shall be authorized to issue policies of medical malpractice insurance to hospitals and other licensed health care providers but need not be the exclusive agency through which such insurance may be written on a primary basis in this state.

4. If the Director, after a public hearing, determines at any time that medical malpractice insurance on a competitive basis can be made available in the voluntary market for either (i) physicians, (ii) hospitals, or (iii) any specific type of other licensed health care provider as defined in the General Laws of Rhode Island, the Association shall thereby cease its underwriting operations for such medical malpractice insurance which he has determined can be made available in the voluntary market.

5. The Association shall, pursuant to the provisions of this regulation and the plan of operation with respect to medical malpractice insurance, have the power on behalf of its members: (a) to issue, or to cause to be issued, policies of insurance to applicant including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year; (b) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions; (c) to assume reinsurance from its members; and (d) to cede reinsurance.

6. The Association and its members are authorized and encouraged to cooperate with the Governor's Commission on Medical Malpractice Reform and the Association's actual or prospective policyholders on all matters pertaining to the commission's duties and the insurance issued or to be issued by the Association.

SECTION 4. PLAN OF OPERATION.

1. On or before the 25th of June, 1975, the directors of the Association shall submit to the Director for his review, a proposed plan of operation, consistent with the provisions of this regulation.

2. The plan of operation shall provide for economic, fair and non-discriminatory administration and for the prompt and efficient availability of medical malpractice insurance, and shall contain other provisions including, but not limited to preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the Asso-

ciation, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the Association.

3. The plan of operation shall be subject to approval by the Director. If the Director disapproves all or any part of the proposed plan of operation, the directors shall within five (5) days submit for review an appropriate revised plan of operation or part thereof. If the directors fail to do so, the Director of Business Regulation shall promulgate a plan of operation or part thereof, as the case may be which shall become effective and operational upon his order.

4. Amendments to the plan of operation may be made by the directors of the Association, subject to the approval of the Director, or shall be made at the direction of the Director.

SECTION 5. POLICY FORMS AND RATES.

1. All policies issued by the Association shall provide for a continous period of coverage beginning with their respective effective dates and terminating automatically at 12:01 a.m. on July first, nineteen hundred seventy-seven unless sooner terminated in accordance with the provisions of this regulation. All such policies shall be issued subject to the group retrospective rating plan and the stabilization reserve fund authorized by this regulation. Policies may be written on a "claims made" or "occurrence" basis. No policy form shall be used by the Association unless it has been filed with the Director and either (a) he has approved it or (b) thirty days have elapsed and he has not disapproved it.

2. Cancellation of the Association's policies shall be governed by the General Laws of Rhode Island, except that the Association may also cancel any of its policies in the event of non-payment of any stabilization reserve fund charged by mailing or delivering to the insured at the address shown on the policy written notice stating when not less than ten days thereafter cancellation shall be effective.

3. The rates, rating plans, rating rules, rating classifications and territories applicable to the insurance written by the Association and statistics relating thereto shall be subject to Title 27, Chapter 9 of the General Laws of Rhode Island, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the association, and such other information as the Director may require. All rates shall be on an actuarally sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting. The Director shall take all appropriate steps to make available to the Association the loss and expense experience of insurers previously writing medical malpractice insurance in this state. To facilitate this procedure all claims will be reported with a duplicate copy to the Director of Business Regulation when reported to the servicing carrier or Association after July 1, 1975. Progress and Evaluation Reports will be submitted on a regular basis.

4. All policies issued by the Association shall be subject to a non-profit group retrospective rating plan to be approved by the Director under which the final premium for all policyholders of the Association, as a group, will be equal to the administrative expenses, loss and loss adjust-

ment expense and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee, on policyholder supplied funds. The standard premium (before retrospective adjustment) for each policy issued by the Association shall be established for portions of the policy period coinciding with the Association's fiscal year on the basis of the Association's rates, rating plan, rating rules, rating classifications and territories then in effect. The maximum final premium for all policyholders of the Association, as a group shall be limited as provided in paragraph 5 of Section 6 of this regulation. Since the business of the Association is subject to the non-profit group retrospective rating plan required by this regulation, there shall be a strong presumption that the rates filed and premiums for the business of the Association are not unreasonable or excessive.

5. The Director shall examine the business of the Association as often as he deems appropriate to make certain that the group retrospective rating plan is being operated in a manner consistent with this regulation. If he finds that it is not being so operated, he shall issue an order to the Association, specifying in what respects its operation is deficient and stating what corrective action shall be taken.

6. The Association shall certify to the Director the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the association. Within sixty (60) days after such certification the Director shall authorize the members of the Association to commence recoupment of their respective shares of the deficit by one of the following procedures: (a) applying a surcharge to be determined by the Association at a rate not

to exceed one (1%) percent of the annual premiums on future policies affording those kinds of insurance which form the basis for their participation in the Association, under procedures established by the Association, or (b) deducting their share of the deficit from past or future taxes due the State of Rhode Island. The Association shall amend the amount of its certification of deficit to the Director as the values of its incurred losses become finalized and the members of the Association shall amend their recoupment procedure accordingly.

7. In the event that sufficient funds are not available for the sound financial operation of the Association, pending recoupment as provided in paragraph six of this section of this regulation, all members shall, on a temporary basis contribute to the financial requirements of the Association in the manner provided for in section eight. Any such contribution shall be reimbursed to the members by recoupment as provided in paragraph six of this section.

SECTION 6. STABILIZATION RESERVE FUND.

1. There is hereby created a stabilization reserve fund. The fund shall be administered by three directors, one of whom shall be the Director of Business Regulation or his deputy. The remaining two directors shall be appointed by the Director of Business Regulation. One shall be a representative of the Association; the other a representative of its policyholders.

2. The directors shall act by majority vote with two directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the

fund. The directors shall not be subject to any personal liability or accountability with respect to the administration of the fund.

3. Each policyholder shall pay to the Association initially a stabilization reserve fund charge equal to one third of the first annual premium payment due for the insurance through the Association. Such charge shall be separately stated in the policy. The Association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge.

4. The Association shall promptly pay to the trustee of the fund all stabilization reserve fund charges which it collects from its policyholders and any retrospective premium refunds payable under the group retrospective rating plan authorized by this regulation.

5. All monies received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the monies held in trust, subject to the approval of the directors. All investment income shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. The monies held in trust shall be used solely for the purpose of discharging when due any retrospective premium charges payable by policyholders of the Association under the group retrospective rating plan authorized by this regulation. Payment of retrospective premium charges shall be made by the directors upon certification to them by the Association of the amount due. Any monies remaining in the fund after all such retrospective premium charges have been paid shall be returned to policyholders under procedures authorized by the directors.

SECTION 7. PROCEDURES.

1. Any licensed physician, hospital or other licensed health care provider shall, on or after the effective date

of the plan of operation, be entitled to apply to the Association for such coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

2. If the Association determines that the applicant meets the underwriting standards of the Association as prescribed in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance (as shown by the insured having failed to make written objection to premium charges within thirty (30) days after billing) then the Association, upon receipt of the premium, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance.

SECTION 8. PARTICIPATION.

1. All insurers which are members of the Association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of each such member (excluding that portion of premiums attributable to the operation of the Association) written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the Association. Each insurer's participation in the Association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the Director.

SECTION 9. DIRECTORS.

The Association shall be governed by a board of eleven directors, to be elected annually. Eight directors shall be elected by cumulative voting by the members of the Asso-

citation, whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. Three directors shall be appointed by the Director of Business Regulation as representatives of the medical profession. The eight member companies serving on the first board shall be elected at the organizational meeting of the members to be held on June 16, 1975, at 10 a.m. The Director shall appoint the other three directors serving on the first board on or before the date of such meeting.

SECTION 10. APPEALS AND JUDICIAL REVIEW.

1. Any applicant to the Association, or any person insured pursuant to this regulation, or their representatives, or any affected insurer, may appeal to the Director within thirty (30) days after any ruling, action or decision by or on behalf of the Association, with respect to those items the plan of operation defines as appealable matters.

2. All orders of the Director made pursuant to this regulation shall be subject to judicial review as provided in the General Laws of Rhode Island, Title 42-35-15.

SECTION 11. ANNUAL STATEMENTS.

The Association shall file in the office of the Director annually on or before the first day of March, a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the Director. The Director may, at any time, require the Association to furnish additional information with respect to its transactions, conditions or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the Association.

SECTION 12. EXAMINATIONS.

The Director shall make an examination into the affairs of the Association at least annually. Such examination shall be conducted and the report thereon filed, and expenses of every such examination shall be borne and paid by the Association in the manner prescribed by Title 27-9-36 of the General Laws of Rhode Island.

SECTION 13. PRIVILEGED COMMUNICATIONS.

There shall be no liability on the part of, and no cause of action of any nature shall arise against the Association, the Director or his authorized representatives or any other person or organization, for any statements made in good faith by them during any proceedings or concerning any matters within the scope of this regulation.

SECTION 14. PUBLIC OFFICERS OR EMPLOYEES.

No member of the board of directors of the stabilization reserve fund who is otherwise a public officer or employee shall suffer a forfeiture of his office or employment of any loss or diminution in the rights and privileges appertaining thereto, by reason of membership on the board of directors of the stabilization reserve fund.

SECTION 15. EFFECTIVE DATE—SEVERABILITY CLAUSE.

This emergency regulation shall take effect June 15, 1975, at 12:01 a.m.

If any provision of this regulation, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this regulation which can be given effect without the invalid provision or application, and to that end the provisions of this regulation are severable.

ROBERT E. LIGUORI
Director of Business Regulation

MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION OF RHODE ISLAND

ARTICLE I

Plan of Operation

Section 1. *Purpose.* The purpose of the Plan is to implement Emergency Regulation XXI of the State of Rhode Island Department of Business Regulation Insurance Division issued pursuant to Title 42, Chapter 35, Section 3, General Laws of Rhode Island, creating a Temporary Joint Underwriting Association to provide medical malpractice insurance for licensed physicians, hospitals and other licensed health care providers, on a self-supporting basis without subsidy from its members.

Section 2. *Definitions.* As used in this Plan:

(a) "Association" means the Temporary Joint Underwriting Association established pursuant to Emergency Regulation XXI of the State of Rhode Island Department of Business Regulation Insurance Division under Section 4 of this Plan.

(b) "Board" means the Board of Directors of the Temporary Joint Underwriting Association as determined and constituted under Section 5 of this Plan.

(c) "Director" means the Director of Business Regulation.

(d) "Medical Malpractice Insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed physician, hospital or other licensed health care provider.

(e) "Member" means every insurer required to be a member of the Association.

(f) "Net direct premiums" means gross direct premiums written on personal injury liability insurance as defined in Title 27-9-2, General Laws of Rhode Island, including the liability component of multiple peril package policies as computed by the Director, less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portion of premium deposits. Reinsurance assumed or ceded shall not be included.

Section 3. *Effective Date and Duration of Plan.*

(a) This Plan shall take effect upon approval by the Director and shall function for a period not to exceed 12:01 a.m., July 1, 1977. Expiration of the Plan on such date will not relieve the Association of liability for coverage assumed prior to such date.

(b) If the Director, after a public hearing, determines at any time that medical malpractice insurance on a competitive basis can be made available in the voluntary market for either (i) physicians, (ii) hospitals, or (iii) any specific type of other licensed health care provider as defined in the General Laws of Rhode Island, the Association shall thereby cease its underwriting operations for such medical malpractice insurance which the Director has determined can be made available in the voluntary market.

Section 4. *Temporary Joint Underwriting Association.*

(a) Every insurer authorized to write, within the State of Rhode Island on a direct basis, personal injury liability insurance as defined in Title 27-9-2, General Laws of Rhode Island, including insurers covering such perils in multiple peril package policies, shall be a member of the Association and shall remain a member as a condition of its authority to continue to transact such kinds of insurance in this State. Each such insurer shall be bound by this Plan.

(b) Every member of the Association shall participate in its writings, expenses, servicing allowances, management fees and losses in the proportion that the net direct premiums of each such member, excluding that portion of premiums attributable to the operation of the Association, written during the preceding calendar year bears to the aggregate net direct premiums written in Rhode Island by all members of the Association. Each member's participation in the Association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the Director.

(c) An insurer ceasing to be licensed or authorized as specified in Subsection (a) of this section shall automatically cease to be a member of this Association effective on the day following the termination or expiration of its authority and shall no longer be bound by this Plan; provided, however, such insurer shall remain liable for any liabilities arising from its participation in the Plan prior to the termination or expiration of such authority.

(d) In the event of the failure of any member, through insolvency or otherwise, to meet liabilities resultant from its participation in the Plan after the Board shall have made written demand upon it to do so, the Board shall report the delinquency to the Director for appropriate action. If they continue beyond a reasonable period of time such liabilities will be assumed by the remaining members, upon appropriate notification by the Board, each taking its proportionate share thereof as determined by the Board. The Association shall be subrogated to the rights of the remaining members in any liquidation proceeding or action against the insolvent or defaulting member and shall have full authority on their behalf to exercise such rights in any action or proceeding.

(e) The Association shall be the exclusive agency through which medical malpractice insurance may be written in Rhode Island on a primary basis for physicians. The Association is authorized to issue policies of medical malpractice insurance to hospitals and other licensed health care providers but need not be the exclusive agency through which such insurance may be written on a primary basis in Rhode Island.

(f) The Association shall, pursuant to Emergency Regulation XXI and this Plan of Operation with respect to medical malpractice insurance, have the power, on behalf of its members:

(1) to issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limits not to exceed one million dollars ($1,000,000) for each claimant under one policy and three million

dollars ($3,000,000) for all claimants under one policy in any one year;

(2) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform these functions;

(3) to assume reinsurance from its members; and

(4) to cede reinsurance.

Section 5. *Administration of the Plan.*

(a) The Association shall be governed by a Board of Directors which shall administer this Plan.

(b) The Board shall consist of eleven (11) members, as follows:

(1) Eight (8) insurers elected annually by cumulative voting by the members of the Association whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year.

(2) Three (3) representatives of the medical profession appointed by the Director.

(c) Not more than one (1) insurer in a group under the same management or ownership shall serve on the Board at the same time.

(d) Any vacancy on the Board shall be filled in the following manner:

(1) If the vacancy is that of an insurer, by a special election called by the Board.

(2) If the vacancy is that of a representative of the medical profession, by appointment by the Director.

(e) A chairman and other officers, as deemed necessary, shall be elected by the Board from among Board members.

(f) At any meetings of the Board, each director shall have one (1) vote. Eight (8) members of the Board shall constitute a quorum for the transaction of business and the acts of a majority of the directors present at a meeting at which a quorum is present shall be the acts of the Board. Voting by proxy on matters which come before the Board shall be permitted, but proxies shall not be permitted in a determination as to whether a quorum is present.

(g) Members of the Board shall receive reimbursement from the Association for their actual and necessary expenses incurred in attending Board meetings and in performing Association business.

Section 6. *Duties and Powers of the Board.*

(a) The Board shall meet as often as may be required to perform the general duties of administration of the Plan. It shall annually file in the office of the Director on or before the first day of March, a statement in the form prescribed by the Director, which shall contain information with respect to the Association's transactions, condition, operations and affairs during the preceding year and it shall furnish to the Director, as he may at any time require, such additional information as would be considered to be material and of assistance in eval-

uating the scope, operation and experience of the Association. Copies of such reports filed with the Director shall be furnished to all members of the Association.

(b) The Board shall have the power on behalf of the Association to:

(1) Make a preliminary assessment of all members of the Association for initial expenses necessary to commence operation of the Plan;

(2) Contract as necessary to provide space, equipment and services to accomplish the Association's purposes;

(3) Appoint and contract for one or more insurers and/or service companies able and willing to provide policy service and claim service on behalf of all other members of the Association. The Board shall provide for the establishment of the scope, terms, standards and compensation applicable to the services to be provided;

(4) A retrospective plan will be established by the Board to allow for possible return of premium to the Health Care Providers or additional assessment if necessary and to attempt to procure reinsurance to cover this eventuality of the cost which will be borne by the stabilization fund;

(5) Establish the commissions payable on business written by the Association;

(6) Provide for statistical coding of insurance written by the Association so that appropriate records may be compiled for the purpose of calculating the adequate premium level for each classification of risk and for studies of the operation of the Plan;

(7) Invest and disburse Association funds and budget expenses;

(8) Collect the Stabilization Reserve Fund charges and pay such charges for the trustees of the Fund in accordance with Section 6, Items 3 & 4 of Emergency Regulation XXI;

(9) Open bank accounts for use in Association business. Reasonable delegation of deposit and withdrawal authority to such accounts for Association business may be made consistent with prudent fiscal authority;

(10) Establish rules for the accounting, collection and disbursement of all premiums;

(11) Make such additional assessments against members of the Association as may be deemed necessary to defray losses and expenses;

(12) Provide for the filing of rules, rates and forms with the Director;

(13) Provide rules of procedure governing the placement of insurance with the Association;

(14) Establish reasonable and objective underwriting standards business placed with the Association;

(15) Provide for such fidelity and surety bonds and such insurance as may be necessary to transact the business of the Association;

(16) Establish an operating Committee and such other committees may be necessary to facilitate the administration of the Plan; and

(17) Review, consider and act on any matters deemed by it to be necessary and proper for the administration of the Plan.

Section 7. *Appeals.* Any applicant to the Association or any person insured thereby, or their representatives or any affected insurer aggrieved with respect to any ruling, action or decision of the Board, or the Association, or any Committee thereof, may within thirty (30) days following such ruling, action, or decision, make appeal to the Director. All orders of the Director made respecting such appeal shall be subject to judicial review as provided in Title 42-35-15, General Laws of Rhode Island.

Section 8. *Plan Amendments.* The Board may recommend and the members of the Association may amend the Plan. Any proposed amendment to the Plan by the Association shall be submitted to the Director for his formal approval unless such proposed amendment, after review by the members of the Association, is disapproved by ten (10) percent or more of such members, provided such dissenting members write at least twenty (20) percent of all the insurance in the state subjecting them to mandatory membership in this Plan. Notice of any proposed amendment by the Association shall be mailed to members by the Board not less than twenty (20) days prior to the final date fixed for voting thereon.

Section 9. *Meetings of the Members.*

(a) A regular meeting of the members shall be held annually on such date, at such place within the State or such other location approved by the Board and at such hour as may be designated by the Board.

(b) Special meetings may be called at any time by the Chairman of the Board. A special meeting shall be called by the Chairman of the Board whenever requested in writing by members whose net direct premiums equal 20% or more of the net direct premiums of all members in the most recent calendar year. Notices of special meetings shall state the purposes thereof. No action shall be taken at a special meeting for a purpose not stated in the notice of meeting except by a majority vote of the entire membership.

(c) Notices of all regular and special meetings shall be sent to each person serving as a representative on the Operating Committee or a Subcommittee of the Operating Committee and to the Director. Each notice shall state the purpose of the meeting and include any proposed changes in rules or procedures.

(d) Notice of each meeting of the members of the Association shall be given at least 10 days prior to the date of the meeting by ordinary mail to each member at its office address according to the records of the Association, except that notice of a meeting to amend the Plan shall be given in the manner provided in Section 8. Notices of meetings to amend the Plan shall include the proposed amendments. The time of all notices shall run from the date of mailing the notice.

(e) Members present in person or proxy and representing 51 percent or more of the members shall constitute a quorum at any meeting of the Asso-

ciation. Except as otherwise provided in Subsection (b) of this Section, when a quorum is present a proposition shall be carried by a majority of the votes cast in person and by proxy.

Section 10. *Indemnification.*

(a) Any person or member made or threatened to be made a party to any action, suit or proceeding, because such person or member served on the Board or on a committee of the Association or was an officer or employee of the Association or as the employee of a servicing carrier and/or servicing company shall be indemnified by the Association against all judgments, fines, amounts paid in settlement, reasonable costs and expenses including attorney's fees and any other liabilities that may be incurred as a result of such action, suit or proceeding, or threatened action, suit or proceeding. Such indemnification shall not be provided in relation to matters as to which such person or member shall be adjudged in such action, suit or proceeding to be liable by reason of breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities in the performance of such person or member's duties or obligations to the Association. With respect to any criminal actions or proceedings indemnification shall only be provided when such person or member had reasonable cause to believe that his or its conduct was lawful. Such indemnification shall be provided whether or not such person or member is a member or is holding office or is employed at the time of such action, suit or proceeding and whether or not any such liability is incurred prior to the adoption of this Plan. Such indemnification shall not be exclusive

of other rights such person or member may have and shall extend to the successors, heirs, executors or administrators of such person or member. In the event of settlement or other termination of a matter before final adjudication, indemnification shall be provided only if the Board is advised by independent counsel that the person or member to be indemnified did not in counsel's opinion commit such breach of duty.

(b) In each instance in which a question of indemnification arises, entitlement thereto, pursuant to the conditions set forth in Subsection (a) of this Section, shall be determined by the Board which shall also determine the time and manner of payment of such indemnification; provided, however, that a person or member who or which has been wholly successful, on the merits or otherwise, in the defense of a civil or criminal action, suit or proceeding of the character described in the Subsection (a) of this Section, shall be entitled to indemnification as authorized in such Subsection. Nothing herein shall be deemed to bind a person or member who or which the Board has determined not be entitled to indemnification, or to preclude such person or member from asserting the right to such indemnification by legal proceedings. Such indemnification as is herein provided shall be apportioned among all members, including any named in any such action, suit or proceeding, pursuant to this Plan.

Section 11. *Records, Audits and Reports.*

(a) The books of account, records, reports and other documents of the Association shall be open and free for examination to the Director at all reasonable hours.

(b) The books of account, records, reports and other documents of the Association shall be open to inspection by all other persons including members only at such times and under such conditions and regulations as the Board shall determine.

(c) The Association shall provide for the making of detailed reports of liability assumed or cancelled, for the drawing up of annual budgets of the Association and for the rendering of accounts to each member at least every twelve months during the continuance of membership.

(d) The books of account of Servicing Carriers and/or Servicing Companies may be audited by a firm of independent auditors designated by the Board.

(e) The Association may audit the records of any member relating to the subject matter of the Plan of Operation and may by rule establish what policies, records, books of account, documents and related material it deems necessary to carry out its functions. Such material shall be provided by the members in the form and with the frequency reasonably required by the Association.

Section 12. *Examinations.* The Director shall make an examination into the affairs of the Association at least annually. Such examination shall be conducted and the report thereon filed, and expenses of every such examination shall be borne and paid by the Association in the manner prescribed by Title 27-9-36 of the General Laws of Rhode Island.

Section 13. *Privileged Communications.* There shall be no liability on the part of, and no cause of action of any nature shall arise against the Association, the Director or his authorized representatives or any other person or organization, for any statements made in good faith by them during any proceedings.

MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION OF RHODE ISLAND

ARTICLE II

Operating Principles

Section 1. *Definitions.* The definitions in Article I, Section 2, apply also to this Article.

In this article the terms "carrier" and "servicing carrier" means servicing carriers and/or servicing companies.

Section 2. *Eligibility of Applicants.*

(a) Any licensed physician, hospital or other licensed health care provider in the State of Rhode Island on or after the date the Plan becomes effective shall be entitled to apply to the Association for medical malpractice insurance. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

(b) If the Association determines that the applicant meets the underwriting standards of the Association as provided in Article III, Rules of Practice, it shall, upon receipt of the premium or such portion thereof as is prescribed in Article III, Rules of Practice, cause to be issued a policy of medical malpractice insurance to such applicant.

(c) Eligibility of applicants for medical malpractice insurance in the Association shall cease whenever the Director, after a public hearing, determines that medical malpractice insurance on a competitive basis can be made available in the voluntary market for either physicians, hospitals or other licensed health care providers, as provided in Article I, Section 3(b).

Section 3. *Participation Ratios.* For the purpose of establishing a basis for allocation of Association expenses and losses as a result of participation requirements reflected in Article I, Section 4(b), each member of the Association shall report statistical information as required by Article III, Rules of Practice, to the Association or permit its statistical agencies, designated by the member, to report the statistical information to the Association.

Section 4. *Member Termination.* For the purpose of further implementing the provisions of Article I, Section 4(c), liabilities of a terminating insurer may be assumed by another insurer under the following circumstances:

(a) when the personal injury liability insurance business of the terminating insurer has been purchased by, transferred to or reinsured totally by such other insurer, and

(b) when the terminating insurer is merged into or consolidated with such other insurer which is to be the continuing insurer.

A purchasing or continuing insurer, however, may be relieved of its obligations for the liabilities of a terminating insurer if another insurer has agreed in a manner satisfactory to the Board to assume such obligations.

Section 5. *Servicing Carriers.*

(a) *Eligibility Requirements.* In selecting carriers, the Board must give consideration to the following:

(1) The carriers must be authorized by the Director and be operating statewide in Rhode Island having reasonable expertise and capability of properly underwriting and process-

ing medical malpractice insurance in the state, properly servicing claims thereon and otherwise maintaining a level of service for all risks submitted through agents or brokers equal to that rendered in the voluntary market.

(2) The carrier must have the necessary facilities in Rhode Island to provide Association risks with the same level of service rendered to its voluntary market. If a carrier normally services its Rhode Island voluntary market from a policy service facility not physically located in Rhode Island, it will not be disqualified to act as a servicing carrier provided its servicing of Association business is maintained at the same level as its voluntary business.

(3) A carrier applying to the Board to be a servicing carrier will be required to estimate any start-up and shut-down expense. It will be the responsibility of the Board to make judgments as to what costs are extraordinary and to give due consideration to any extraordinary expense reimbursement applied for or expected.

(b) *Service Standards.* A servicing carrier must:

(1) accomplish confirmation of classifications and territories by the use of classification checks, credit reports, or other appropriate means and must properly underwrite and rate risks;

(2) issue policies to applicants by the expiration date of 30-day binders;

(3) have the ability to carry out all subsequent policy transactions and servicing of claims on a timely basis;

(4) have the ability to carry out all necessary accounting procedures, including, but not limited to (i) Billing and Collection and (ii) Commission payments and statements to producers;

(5) have the ability to collect the necessary data to disburse commission payments to agents and have the ability to store this data and report same to the Internal Revenue Service, if required; and

(6) generate the statistical and accounting information in report format required under Article III, Rules of Practice.

(c) *Allowances.* A servicing carrier will be reimbursed for Association business on the following basis:

(1) Hospital—six percent (6%) of written premium for operating costs, including loss prevention and inspection services, excluding claim expense.

Physicians—four percent (4%) of written premium for operating costs, excluding claim expense.

All other licensed health care providers—either of the percentage expressed above depending upon the category—either hospital or physicians—within which they fall most closely.

(2) A service fee of one percent (1%) of written premium.

(3) Allocated Loss Adjustment Expense shall be charged against the Association as part of the incurred loss.

(4) Unallocated Loss Adjustment Expense shall be charged at an amount equal to ten percent (10%) of the sum of the reported losses incurred plus the Allocated Loss Adjustment Expense.

(5) The Board in its sole discretion may offer or allow a servicing carrier reimbursement in whole or in part for specific extraordinary expense incurred in qualifying for continuing as or ceasing to be a servicing carrier. Such expense must be explained and supported in such detail as required by the Board, must be in its judgment significantly in excess of the normal additional expense expected to be incurred and must actually be incurred before reimbursement.

(6) The Board in its sole discretion may authorize reimbursement of servicing carriers for normal insurance business losses incurred in connection with Association business. Such normal business losses shall be as determined by the Board but shall not include any loss or expense incurred as a result of fraud or dishonesty on the part of a servicing carrier's personnel (including but not limited to independent adjusters and agents), and each servicing carrier shall hold the Association harmless from and reimburse it for any such loss or expense charged to the Association.

(d) *Extrahazardous Risks.* If an applicant presents a risk which is greater than that contemplated by the rate normally applicable, the servicing carrier shall consult with the Board before submission to the Director for an increase in such rate. An increase in rate approved by the Director shall be deemed to include any applicable additional charge.

(e) *Appointment of Agents; Commissions.*

(1) Every agent licensed to solicit personal injury liability insurance in the State of Rhode Island shall be eligible for appointment to a servicing carrier upon application to the Association. Individual agents who are part of an agency entity may be appointed to one servicing carrier.

(2) A 5% commission per policy is payable to the producing agent.

Section 6. *Amendments.* No amendment of this Article by the Board shall be effective unless sixty (60) days prior notice in writing of the amendment and the reasons therefor shall have been given Association members, unless after such notice an earlier effective date is ratified by majority vote of the members. If a special meeting of the members is called pursuant to Part I, Section 9(b), to consider the amendment, the proposed amendment shall not be effective until after such meeting. Any such amendment shall be subject to the approval of the Director.

STATE OF RHODE ISLAND

DEPARTMENT OF BUSINESS REGULATION

INSURANCE DIVISION

Regulation XXI

Medical Malpractice Joint Underwriting Association
of Rhode Island

Effective April 9, 1976

PHILIP W. NOEL, Governor

Robert E. Liguori,
Director, Department of Business Regulation

SECTION 1. *Statement of Findings and Purpose.*

The Director of Business Regulation hereby finds that:

1. There has existed a lack of a competitive stable market for medical malpractice insurance in the State of Rhode Island for providers of health care.

2. As a result, Emergency Regulation XXI was promulgated on June 16, 1975, to provide a stable facility for medical malpractice insurance in Rhode Island, which regulation expires at 12:00 midnight April 8, 1976.

3. Medical malpractice insurance has not been made reasonably available on a competitive stable basis for a significant majority of any class, type or group of providers of health care in the voluntary market which has resulted in a peril to the health care delivery system in Rhode Island and to the public health, safety and welfare of the people of the State of Rhode Island.

4. There is a need to provide a continuing stable facility for medical malpractice insurance prior to April 9, 1976.

Therefore, in accordance with Title 42, Chapter 14.1, of the General Laws of Rhode Island, there is hereby promulgated and adopted the following regulation which shall be known as the Medical Malpractice Joint Underwriting Association of Rhode Island.

The basic purpose of this regulation is to provide for medical malpractice insurance in Rhode Island.

SECTION 2. *Definitions.*

As used in this regulation:

1. "Association" means the Joint Underwriting Association established pursuant to the provisions of this regulation.

2. "Medical Malpractice Insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering or failing to render professional service by any provider of health care.

3. "Provider of Health Care" means (a) any licensed physician, hospital or other licensed health care provider as defined in the General Laws of Rhode Island; and (b) any other group, type or category of individual or health related facility that the Director determines, with or without a hearing, to be necessary for the continued delivery of health care in Rhode Island.

4. "Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of health care that would normally be available and underwritten under a comprehensive general liability form of insurance, except liabilities that may arise out of the ownership or use of any motor vehicles and workers compensation insurance.

5. "Net direct premiums" means gross direct premiums written on personal injury liability insurance (as defined in Title 27-9-2 of the General Laws of Rhode Island) including the liability component of multiple peril

package policies as computed by the Director, less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

6. "Director" means the Director of Business Regulation of the State of Rhode Island.

SECTION 3. *Joint Underwriting Association.*

1. A Joint Underwriting Association is hereby created, consisting of all insurers authorized to write, within this state on a direct basis, personal injury liability insurance as defined in Title 27-9-2 of the General Laws of Rhode Island, including insurers covering such perils in multiple peril package policies. Every such insurer shall be a member of the Association and shall remain a member as a condition of its authority to continue to transact such kinds of insurance in this State.

2. The purpose of the Association shall be to continue to provide a market for medical malpractice insurance on a self-supporting basis.

3. The Association shall continue to underwrite medical malpractice insurance without interruption under the programs approved under Emergency Regulation XXI, including all policies and obligations assumed thereunder. The Association shall also be authorized to underwrite incidental coverages for any provider of health care but only if such provider of health care shall be insured by the Association for medical malpractice.

4. The Association shall be the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis for physicians but need not be the

exclusive agency through which medical malpractice insurance may be written in this state for all other providers of health care. In the event, however, that legislation is enacted amending Title 42-14.1-1 removing the requirement that the Association be the exclusive agency for medical malpractice insurance for physicians, then the Association need not be the exclusive agency for such insurance, and any insurers authorized to write medical malpractice insurance in this State shall be allowed to do so subject to the provisions of Title 27, Chapter 9 of the General Laws of Rhode Island.

5. The Association shall, pursuant to the provisions of this regulation and the plan of operation with respect to medical malpractice insurance, have the power on behalf of its members: (a) to issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under one policy in any one year and three million dollars for all claimants under one policy in any one year; (b) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions; (c) to assume reinsurance from its members; and (d) to reinsure its risks in whole or in part.

SECTION 4. *Plan of Operation.*

1. The plan of operation of the Association submitted to the Director under the Emergency Regulation shall stand as approved for the Association and shall serve as the accepted plan for the purpose of this regulation subject to Section 9 of this regulation relating to directors.

2. The plan of operation shall continue to provide for economic, fair and non-discriminatory administration and

for the prompt and efficient availability of medical malpractice insurance and incidental coverages and shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the Association, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the Association.

3. Amendments to the plan of operation may be made by the directors of the Association, subject to the approval of the Director, or shall be made at the direction of the Director.

SECTION 5. *Policy Forms and Rates.*

1. All policies issued by the Association shall be on an annual basis unless sooner terminated in accordance with the provisions of this regulation. All such policies shall be issued subject to the group retrospective rating plan and the stabilization reserve fund authorized by this regulation. Policies may be written on a "claims made" or "occurrence" basis. No policy form shall be used by the Association unless it has been filed with the Director and either (a) he has approved it or (b) thirty (30) days have elapsed and he has not disapproved it.

2. Cancellation of the Association's policies shall be governed by the General Laws of Rhode Island, except that the Association may also cancel any of its policies in the event of non-payment of any stabilization reserve fund charges by mailing or delivering to the insured at the address shown on the policy written notice stating when not less than ten (10) days thereafter cancellation shall be effective.

3. The rates, rating plans, rating rules, rating classification and territories applicable to the insurance written by the Association and statistics relating thereto shall be subject to Title 27, Chapter 9 of the General Laws of Rhode Island, giving due consideration to the past and prospective loss and expense experience for such insurance written and to be written in this state, trends in the frequency and severity of losses, the investment income of the Association, and such other information as the Director may require. All rates shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting. The Director shall take all appropriate steps to make available to the Association the loss and expense experience of insurers previously writing such insurance in this state. To facilitate this procedure all claims will be reported with a duplicate copy to the Director of Business Regulation when reported to the servicing carrier or Association after July 1, 1975. Progress and Evaluation Reports will be submitted on a regular basis.

4. All policies issued by the Association shall be subject to a non-profit group retrospective rating plan to be approved by the Director under which the final premium for all policyholders of the Association, as a group, will be equal to the administrative expenses, loss and loss adjustment expense and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee on policyholder supplied funds. The standard premium (before retrospective adjustment)

for each policy issued by the Association shall be established for portions of the policy period co-inciding with the Association's fiscal year on the basis of the Association's rates, rating plan, rating rules, rating classifications and territories then in effect. The maximum final premium for all policyholders of the Association, as a group shall be limited as provided in paragraph 5 of Section 6 of this regulation.

5. The Director shall examine the business of the Association as often as he deems appropriate to make certain that the group retrospective rating plan is being operated in a manner consistent with this regulation. If he finds that it is not being so operated, he shall issue an order to the Association, specifying in what respects its operation is deficient and stating what corrective action shall be taken.

6. The Association shall certify to the Director the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the Association. Within sixty (60) days after such certification the Director shall authorize the members of the Association to commence recoupment of their respective shares of the deficit by one of the following procedures: (a) applying a surcharge to be determined by the Association at a rate not to exceed one (1%) percent of the annual premiums on future policies affording those kinds of insurance which form the basis for their participation in the Association, under procedures established by the Association, or (b) deducting their share of the deficit from past or future taxes due the State of Rhode Island. The Association shall amend the amount of its certification of deficit to the Director as the values of its incurred losses become finalized and the members of the Association shall amend their recoupment procedure accordingly. This section and any authorizations hereunder shall only apply to medical malpractice insurance and no other forms of insurance.

7. In the event that sufficient funds are not available for the sound financial operation of the Association, pending recoupment as provided in paragraph 6 of this section of this regulation, all members shall, on a temporary basis contribute to the financial requirements of the Association in the manner provided for in Section 8. Any such contribution shall be reimbursed to the members by recoupment as provided in paragraph 6 of this section.

SECTION 6. *Stabilization Reserve Fund.*

1. There is hereby created a stabilization reserve fund. The fund shall be administered by three directors, one of whom shall be the Director of Business Regulation or his deputy. The remaining two directors shall be appointed by the Director of Business Regulation. One shall be a representative of the Association, the other a representative of its policyholders.

2. The directors shall act by majority vote with two directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the fund. The directors shall not be subject to any personal liability or accountability with respect to the administration of the fund.

3. Each insured except so-called "physicians-in-training" shall pay to the Association initially a stabilization reserve fund charge equal to one-third of the first annual

premium due for medical malpractice insurance through the Association. So-called "physicians-in-training" who are entitled to a reduced rate for their classification by virtue of their training status shall pay an initial stabilization reserve fund charge equal to one-third of their first annual premium but shall also be required upon completion of their training to pay an additional stabilization reserve fund charge equal to one-third of the full premium by class less any sums already paid during their training period. Such charge shall be separately stated in the policy. The Association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge. No such reserve fund shall be allowed for any coverage provided by the Association other than medical malpractice.

4. The Association shall promptly pay to the trustee of the fund all stabilization reserve fund charges which it collects from its policyholder and any retrospective premium refunds payable under the group retrospective rating plan authorized by this regulation.

5. All monies received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the monies held in trust, subject to the approval of the directors. All investment income shall be credited to the fund. The monies held in trust shall be used solely for the purpose of discharging when due any retrospective premium charges for medical malpractice insurance payable by policyholders of the Association under the group retrospective rating plan authorized by this regulation, and for payment of such taxes as may be payable on the investment income of the fund or otherwise by virtue of the existence of such fund. Payment of retrospective premium charges and taxes shall be made by the directors upon certification to them by the Association

of the amount due. Any monies remaining in the fund after all such retrospective premium charges and taxes have been paid shall be returned to policyholders under procedures authorized by the directors.

SECTION 7. *Procedures.*

1. Any provider of health care shall, on or after the effective date of the plan of operation, be entitled to apply to the Association for medical malpractice insurance and incidental coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

2. If the Association determines that the applicant meets the underwriting standards of the Association as prescribed in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance (as shown by the insured having failed to make written objection to premium charges within thirty (30) days after billing) then the Association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy or policies of insurance.

SECTION 8. *Participation.*

1. All insurers which are members of the Association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of each such member (excluding that portion of premiums attributable to the operation of the Association) written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the Association. Each insurer's

participation in the Association shall be determined annually on the basis of such net direct premiums written during the preceeding calendar year, as reported in the annual statements and other reports filed by the insurer with the Director.

SECTION 9. *Directors.*

The Association shall be governed by a board of fifteen directors. Eight directors shall represent member companies and be elected annually by cumulative voting by the members of the Association whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. The remaining seven directors shall be appointed annually by the Director of Business Regulation six of whom shall be representatives of the medical profession, and one of whom shall be a representative of the hospitals. The annual meeting of the board of directors shall be the anniversary of the effective date of this Regulation. Directors shall serve until their successors are duly elected or appointed as the case may be.

SECTION 10. *Appeals and Judicial Reviews.*

1. Any applicant to the Association, or any person insured pursuant to this regulation, or their representatives, or any affected insurer, may appeal to the Director within thirty (30) days after any ruling, action or decision by or on behalf of the Association, with respect to those items the plan of operation defines as appealable matters.

2. All orders of the Director made pursuant to this regulation shall be subject to judicial review as provided in the General Laws of Rhode Island, Title 42-35-15.

SECTION 11. *Annual Statements.*

The Association shall file in the office of the Director annually on or before the first day of March, a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the Director. The Director may, at any time, require the Association to furnish additional information with respect to its transactions, conditions or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the Association.

SECTION 12. *Examinations.*

The Director shall make an examination of the affairs of the Association at least annually. Such examination shall be conducted and the report thereon filed, and expenses of every such examination shall be borne and paid by the Association in the manner prescribed in Title 27-9-36 of the General Laws of Rhode Island.

SECTION 13. *Privileged Communications.*

There shall be no liability on the part of, and no cause of action of any nature shall arise against the Association, the Director or his authorized representatives or any other person or organization, for any statements made in good faith by them during any proceedings or concerning any matters within the scope of this regulation.

SECTION 14. *Public Officers or Employees.*

No member of the board of directors of the stabilization reserve fund who is otherwise a public officer or employee

shall suffer a forfeiture of his office or employment or any loss or diminution in the rights and privileges appertaining thereto, by reason of membership on the board of directors of the stabilization reserve fund.

SECTION 15. *Effective Date—Severability Clause.*

This regulation shall take effect April 9, 1976 at 12:01 a.m.

If any provision of this regulation, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this regulation which can be given effect without the invalid provision or application, and to that end the provisions of this application are severable.

/s/ ROBERT E. LIGUORI

ROBERT E. LIGUORI
Director of Business Regulation